UNIVERSITY OF CALIFORNIA, SANTA BARBARA

A Pilot Study: Youth Participatory Engagement and Action in Mental Health

A Dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Counseling, Clinical, and School Psychology

by

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September 2024

The dissertation of Natalie A. Lárez is approved.

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CURRICULUM VITAE

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EDUCATION & TRAINING

2023 –	**Ann & Robert H. Lurie Children's Hospital of Chicago** APPIC Health Service Psychology Internship (APA Accredited) Track: Pediatric Psychology; Rotations: Inpatient Unit, Gender & Sex Development, Consult Liaison service, Hematology/ Oncology, Substance Use Prevention Program, Forensic Assessment for Immigration Relief clinic
2019 –	**University of California, Santa Barbara** PhD Candidate, Counseling, Clinical, & School Psychology (APA Accredited) Primary Advisor: Jill D. Sharkey, PhD Dissertation: A Pilot Study: Youth Participatory Engagement and Action in Mental Health (YPEAM)
2021	**University of California, Santa Barbara** Master of Education (M.Ed.) in Counseling Clinical and School Psychology
2015-2019	**University of Arizona** Bachelor of Science Literacy, Learning, and Leadership Emphasis on Leadership for Equity, Access, and Success in Education Family Studies and Human Development

GRANTS & FELLOWSHIPS

Awarded

2020-2024	Robert Wood Johnson Foundation, Health Policy Research Scholar ($124,000)
2022	National Program Center at Johns Hopkins Bloomberg School of Public Health, Health Policy Research Scholar Dissertation Award ($10,000)
2022	UCSB Travel Grant ($900)
2019-2020	CCSP First-Year Fellowship ($15,000)
2019	National Institute of Health (NIH), Research Supplement to Promote Diversity in Health-Related Research ($14,524; 3R01DK110528-03S1**,** PI: Perfect)
2017	Pathways to Doctoral Studies in Education-Related Fields: Underrepresented Students: Access, Wellness, and Relational Determinants of School Success (AWARDSS) Program

ADDITIONAL TRAINING

2020 – 2024	**Robert Wood Johnson Foundation, Baltimore, MD** **Johns Hopkins Bloomberg School of Public Health** *Health Policy Research Scholar* Participate in didactics and receive additional training in public policy, public health, and health equity. Work alongside interdisciplinary scholars from across the nation in devising solutions that inform public policy from research.

CLINICAL EXPERIENCE

2023 - **Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago IL**
Pritzker Department of Child and Adolescent Psychiatry
Pediatric Psychology Pre-Doctoral Intern
Director of Clinical Training**:** Kelly Lowry, PhD
Providing direct mental health services to children in various settings, such as an inpatient unit for children with severe mental health concerns, the Gender & Sex Development clinic which provides gender affirming care, the consult service supporting children throughout the hospital with medical and mental health needs, the hematology, oncology, & transplant service, and conduct neuropsychological evaluations. I also engage in research and clinical services through the Adolescent Medicine Substance Use Prevention Program (SUPP) and the Forensic Assessment and Immigration Relief (FAIR) clinic.

2022 - 2023 **Cottage Hospital, Santa Barbara, CA**
Department of Psychiatry and Addiction Medicine
Clinical Extern
Supervisor: Ariel Schieder, LCSW; Gonzalo Gonzalez, LMFT
University-based Supervisor: Heidi Zetzer, PhD
Provided inpatient biopsychosocial intake evaluations and intervention services as part of a multidisciplinary team at an adult in-patient psychiatric detox unit. Assessed adult patients to identify treatment goals and support discharge planning to lower level of care. Facilitated therapeutic groups for general well-being and substance recover and wellness.

2021- 2023 **Parent-Child Interaction Therapy (PCIT) Clinic, Santa Barbara, CA**
Department of Counseling, Clinical, and School Psychology
PCIT Student Clinician
Supervisor: Miya Barnett, PhD
Provided PCIT, in Spanish or English, (in person and telehealth) to families with children experiencing externalizing problems including disruptive behavior disorders. Lead co-therapy with junior clinicians. Earned certification as a PCIT therapist.

2021-2022 **Hapgood Elementary (Dual Immersion), Lompoc, CA**
Lompoc Unified School District
Advanced Practicum Student
Supervisor: Monette Tijerina, M.A
University-based Supervisor: Erin Dowdy, PhD
Conducted, wrote, and presented psychoeducational assessments in Spanish and English. Provided individual and group therapy for students in k – 6^{th} grade who have anxiety, depression, trauma, significant learning disability, and ADHD. Provided suicide risk and management services.

2020-2021 **La Patera Elementary, Goleta, CA**
Goleta Union Elementary School District
Practicum Student
Supervisor: Alex Serrano-Ramírez, M.S, L.E.P.
University-based Supervisor: Jill D. Sharkey, PhD
Conducted, wrote, and supported psychoeducational evaluations to determine special education eligibility. Conducted a behavioral analysis in consultation with

teachers, parents, and administrative staff. Provided individual and group therapy for students in a k -6th school setting using CBT-based curriculums.

PUBLICATIONS

Peer-reviewed manuscripts

1. **Lárez, N. A**. & Perfect, M.M. (2023, August). Type 1 Diabetes Mellitus. In Perfect, M. M., Riccio, C., & Bray, M. *Health-Related Conditions in Children and Adolescents: A Guidebook for Educators and Service Providers.*
2. **Lárez, N.A.,** Sharkey, J. D., Frattaroli, S., Avila, E.*, & Medina, A.* (2023, July). Implementing youth participatory action research at a continuation high school. *Health services research*, *58 Suppl 2*(Suppl 2), 198–206. https://doi.org/10.1111/1475-6773.14190
3. **Lárez, N.A.** Freeman, M., Sabnis, S., & Whitford, D. (2023, June). Advocating for Equity and Fairness in Alternative Education Placements. *National Association for School Psychologists Communique, 51* (8).
4. **Lárez, N. A.,** Yohannan, J., Crossing, A., & Diaz, Y. Understanding and Responding to Intergenerational Trauma. (2022, January). *National Association for School Psychologists Communique, 50* (5).
5. Whaling, K., der Sarkissian, A., **Lárez, N.A.,** Sharkey, J., Allen, M.A., Nylund-Gibson, K. (2021, December). Child maltreatment prevention service cases are significantly reduced during the COVID-19 pandemic: a longitudinal investigation into unintended consequences of quarantine. Child Maltreatment. *0* (0), 1-8. https://doi.org/10.1177/10775595211051318
6. **Lárez, N. A**., & Sharkey, J.D. (2021, November 1). Decision-Making Model for Addressing Role Conflict for Psychology trainees when Supporting Family and Community. Frontiers in Cultural Psychology. doi:10.3389/fpsyg.2021.745368
7. Carlson, J. S., Darr, C., Yohannan, J., Turley, M., **Lárez, N. A**., & Perfect, M.M. (2018, December). Prevalence of Adverse Childhood Experiences in school-aged youth: A systematic review (1990- 2015). *International Journal of School and Educational Psychology.*

Publications in Preparation

8. Summersett Williams, F., **Larez, N.A.,** Mondesir, L., Curtis, K., Quad, N, Valdivia, S., & Brown, J., Hogue, A. (In prep). Brief substance use screening and intervention in schools for adolescents with chronic medical conditions: a study protocol to implement family-focused SBIRT within School-Based Health Centers.
9. Bouchard, I., **Lárez, N.A.,** Sharkey, J.D., Munguia, D., Gutierrez, V. (In Prep). Mental Health Service Utilization among Undocumented College Students Through a Transaction Ecological Lens.

*Denotes youth co-researchers

PRESENTATIONS

1. **Larez, N.A.,** Green Rosas, Y., & Sharkey, J.D. (2022, August). *Supporting Diverse Psychology Trainees: Considering Role Conflict and Community Workers in Training.* Presented at the American Psychological Association conference, Minneapolis, Minnesota.
2. **Larez, N.A.** & Sharkey, J.D. (2021, December). *Transformational Resistance: Youth as Researchers and Leaders for Change.* Presented at the virtual California Alcohol Policy Alliance summit.

3. **Larez, N. A**., Avila, E., Janes, L, & Sharkey, J. D. (2021, February). *Facilitating Student-Led Research and Activism towards Higher Graduation Rates.* Presented at the virtual National Association of School Psychologists conference.
4. Fairchild, A. Perfect, M.M., **Larez, N.A.,** Meyers, T., & Mullins, V. (2019, August). *Perspectives of Underrepresented Students on Effective Mentored Research Training.* Presented a panel at the American Psychological Association, Chicago, IL.
5. Perfect, M.M., Brown, B., & **Larez, N.A**. (2018, August). *Professional development in minority populations.* Facilitated a panel at the American Psychological Association Conference, San Francisco, CA.
6. **Larez, N. A.,** & Perfect, M. M. (2018, August). *Symptomatic Effects of Childhood Trauma: Resiliency as a mediator in relation to trauma exposed adolescents' school outcomes among youth with type 1 diabetes.* Poster presented at the Undergraduate Research Opportunities Consortium's Poster Session, The University of Arizona, Tucson, AZ.
7. **Larez, N. A.,** & Perfect, M. M. (2018, August). *Symptomatic Effects of Childhood Trauma: Resiliency as a mediator in relation to trauma exposed adolescents' school outcomes among youth with type 1 diabetes.* Paper presented at the Undergraduate Research Opportunities Consortium's Colloquia, The University of Arizona, Tucson, AZ.
8. Perfect, M.M., Frye, S. S., Bluez, G.P., & **Larez, N.A.** (2018, June). *Effects of a sleep extension intervention on glucose control in youth with type 1 diabetes.* Poster presented at the American Diabetes Association Conference, Orlando, FL.

RESEARCH EXPERIENCE

2023 **Ann & Robert H Lurie Children's Hospital**
Northwestern University Feinberg School of Medicine
PI: Faith Summerset Williams, PhD
Co-authoring manuscript publications, with qualitative and quantitative data, on implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) of substance use for youth with chronic illness, in various settings (e.g., hospital, school-based health centers).

2022-2023 **Dissertation: A Pilot Study: Youth Participatory Engagement and Action in Mental Health (YPEAM)**
University of California, Santa Barbara
Chair: Jill D. Sharkey, PhD
Co-Chairs: Erin Dowdy Quirk, PhD; Alison Cerezo, PhD
Conducted a feasibility and acceptability study of implementation of pilot curriculum-based intervention at a local youth community organization aimed at reducing stigma and increasing mental health knowledge. The curriculum is structured to be participatory and was evaluated using mixed methodology.

2018-2021 **Sharkey Lab**
University of California, Santa Barbara
PI: Jill D. Sharkey, PhD
Comprehensive Support & Improvement for a Local Continuation High School
Lead project coordinator for a 3-year Comprehensive Support and Improvement plan for a local continuation high school by implementing Youth Participatory Action Research that was funded by the California Department of Education. Conducted group sessions that discussed stigma, systems-level influences on their education and mental health, and devised youth-led solutions for their school

setting in order to improve retention, graduation rates, mental health, and attendance.

Supported Mentorship of Undergraduate Students

Supported the mentorship of several undergraduate McNair and non-McNair students in project development, journal outlets, presentations, and methodology.

2019 **NIH Diversity Fellow: Family Routines Enhancing Adolescent Diabetes in Optimizing Management (FREADOM) lab**
University of Arizona, NIH 3R01DK110528-03S1
PI: Michelle M. Perfect, PhD
Supported project coordination for a Randomized Control Trial. Managed participant communication, coordination with physicians, scheduling tasks, and worked with families to implement behavioral changes to optimize glucose management. Executed home visits with Spanish- and English-speaking families to gather sleep data using polysomnography and problem solve any changes in routine within their family structure.

2018 – 2019 **Family Routines Enhancing Adolescent Diabetes in Optimizing Management (FREADOM) lab**
University of Arizona, NIH R01-DK-110528
PI: Michelle M. Perfect, PhD
Conducted secondary data analysis of the Resiliency Scale for Children and Adults (RSCA), school outcomes, and trauma symptoms of youth (12 – 18 years old) with a diagnosis of type 1 diabetes using SPSS. Assisted in composing three external grants for the Institute of Educational Services (IES), National Institute of Health (NIH), and the William T. Grant Foundation.

2018 - 2019 **Smith Lab**
University of Arizona
PI: Eric Smith, PhD
Assisted in study design of a pilot study and literature reviews on projects related to impact of study guides on student learning. Support participant simulations.

TEACHING EXPERIENCE

Instructor of Record

2022 **Positive Psychology (CNCSP 112)**
University of California, Santa Barbara

Teaching Assistant

2022 – 2023 **Second-Year Fieldwork Supervision (CNSP 274DEF)**
University of California, Santa Barbara
Provided supervision for 2nd year practicum students in the provision of assessment, intervention, and consultation services within school settings.

2023 **Introduction to Chicanx Studies (CHST 1A)**
University of California, Santa Barbara

2022 **Psychology of Gender (CNCSP 114)**
University of California, Santa Barbara

2021, 2022 **Positive Psychology (CNCSP 112)**
University of California, Santa Barbara

SERVICE AND CERTIFICATIONS

2022 Parent Child Interaction Therapy Therapist
2021 -2023 NASP Social Justice Committee
2021 Trauma-Focused Cognitive Behavioral Therapy

2021 Pillars of Teaching Assistantship Program
2020 NASP Student Leader

PROFESSIONAL AFFILIATIONS

National Association School Psychology (NASP)
American Psychological Association (APA)
Society of Clinical Child and Adolescent Psychology
Parent-Child Intervention Therapy (PCIT) International

Abstract

A Pilot Study: Youth Participatory Engagement and Action in Mental Health

By: Natalie A Lárez

Adolescence is a crucial point for mental health intervention given that three-quarters of all life-time mental health concerns emerge by the age of 24 (National Alliance of Mental Health, 2021). Limited engagement in treatment is often due to structural barriers (e.g., transportation, cost, access) and other intrapersonal barriers, such as low perceived need and limited knowledge about mental health (Radez et al., 2019). My dissertation presents an initial feasibility and acceptability study of a modular mental health promotion program that I created, Youth Engagement and Action in Mental Health (YPEAM), which aims to increase mental health literacy, decrease stigma, and influence the perceived effectiveness of mental health treatment among youth in a community organization.

YPEAM was implemented at a youth community organization with eight participants between the ages of 12 – 17 years old across 13, 1-hour sessions. By using a convergent mixed methods design, I was able to answer three main questions: how feasible (i.e., easy or difficult) is the implementation of YPEAM within a community youth center, how acceptable (i.e., how much youth enjoyed and valued it) was it among the youth, and how did it affect self-reported levels of stigma about mental health and their knowledge of mental health? Pre- and post-YPEAM implementation survey data and semi-structured interviews offered insight into how YPEAM may contribute to alleviating some of the initial barriers to youth seeking mental health support that drove the development of this unique program.

Results regarding feasibility indicated a recruitment rate of 75% of youth that were already involved in the center and met age criteria. Six of the eight youth attended all 13

sessions. Regarding acceptability, one youth reported that the flexibility of the curriculum was “a nice freedom to have.” This finding supports one of the initial goals of YPEAM, which was to use youth voices to increase engagement in mental health programs. Additional semi-structured qualitative data indicated favorable views of the program, while also providing suggestions for future iterations of the program. Survey results indicated that all participants “strongly agreed” or “agreed” when asked if they liked YPEAM. Results related to stigma and mental health knowledge were evaluated using qualitative and quantitative data. In their semi-structured interviews after the program, several youths reported feeling more confident in their ability to recognize mental health symptoms and knowing how to seek support. Nearly all youth reported reduced mental health stigma scores after YPEAM.

This pilot study provided insight into implementation of a novel program within a community center and highlighted the potential benefits of the curriculum. This study provides an example of using the Youth Participatory Action Research (YPAR) framework as a guide for a novel mental health promotion program. YPEAM incorporated youth decisions into the delivery of a mental health program, which showed a positive influence on some barriers to youth engagement, such as stigma and mental health literacy. Additionally, given that the seven of the eight participants of the study sample were from a marginalized identity, this study aligns with literature that highlights that YPAR strategies may benefit marginalized youth. Taken together, my dissertation contributes to the literature base of how mental health promotion programs can be specifically tailored to youth’s needs and shift how researchers are developing and implementing prevention efforts. YPEAM provides a model of how to create and implement flexible curriculums so that they are more socially, culturally, and geographically attuned to youth mental health needs.

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Chapter I: Introduction

The United States surgeon general and other health care associations (e.g., American Academy of Pediatrics, American Academy of Child, and Adolescent Psychiatry) have declared the current state of mental health needs of children and adolescents as a national emergency (US Department of Health and Human Services, 2021). Nearly one in six youth, aged 6-17, meet diagnoses for a mental health disorder every year and 75% of lifetime mental illness begins before the age of 24 – underscoring that intervening prior to the age of 24 is an important public health target (National Alliance of Mental Health, 2021). Importantly, while it is true that all youth experience limited access to mental health supports, it is well known that youth with minoritized identities and/or youth facing systemic problems (e.g., limited access due to geographical location, poverty, limited transportation) experience mental health concerns at elevated rates while also experiencing less access to care.

While there remains an increased need for mental health services among for adolescents, there is limited engagement in treatment due to structural barriers (e.g., transportation, cost, access) and other barriers, such as low perceived need and limited knowledge about mental health (Radez et al., 2019). Notably, there are recommendations in the literature that have shown promise in increasing engagement in mental health services for young people. One is increasing the number of programs and treatment models that center adolescent voices and decision-making. Given that youth engagement in mental health programming remains a concern, it is important to focus on innovative mental health programs to proactively support the well-being of youth with mental health prevention and promotion programs, especially for youth from marginalized identities.

The purpose of this dissertation is to present an initial feasibility and acceptability study of a mental health promotion intervention. The mental health promotion program, Youth Engagement and Action in Mental Health (YPEAM), is grounded in the evidence that youth participation (i.e., using lived experiences to make changes to curriculum/ programing) increases engagement (i.e., attendance, playing an active role in programs) in programing. YPEAM aims to influence three primary outcomes: (a) increase mental health literacy, (b) decrease stigma, and (3) influence the perceived effectiveness of mental health treatment among youth in a youth community organization.

Organization

In the following pages of this introductory chapter, I present the current literature that has contributed to the motivation and development of the YPEAM program. I begin by providing a broad overview of current literature of therapy treatment for adolescents and highlight disparities in treatment for marginalized youth. This is followed by an overview of literature related to youth engagement in mental health programing, including understanding facilitators and barriers to youth engagement that contribute to accessing treatment and programs. I review youth centered programs and the benefits they have demonstrated for youth engagement in mental health treatment. I also provide a general overview of mental health promotion and prevention programs, which includes a specific focus of mental health programming within community-based organizations (CBOs). I then explain the conceptual framework that guided the development and evaluation of the YPEAM program. Lastly, I describe the YPEAM program that was influenced by both the theoretical conceptual framework and feedback from community partners prior to implementation.

In chapter two of this dissertation, I describe the methodology for conducting the YPEAM program and the evaluation of the program. In chapter three, I present the qualitative and quantitative results related to feasibility, acceptability, and outcomes of YPEAM. In chapter four, I present interpretation of the results, limitations of the current study, and recommendations for future research related to youth centered mental health prevention and promotion programs within CBOs.

Treatments for Child and Adolescent Mental Health Needs

Individual psychotherapy treatment for children and adolescents has proven to have varied effects for improvement in symptoms. In a metanalysis study using 223 studies of children between 4 – 18 years old, Kazdin et al. (1990), found a large effect size (0.88) for treatment group versus no treatment control group. A more recent metanalysis using 150 outcomes studies, demonstrated a medium effect size (0.54) for post-treatment effects (Weisz et al., 1995). When focusing on specific diagnosis (e.g., anxiety, depression) in children and adolescents, treatment outcomes continue to demonstrate varied effects. A metanalysis focused on anxiety treatment for children and adolescents found moderate to large effect sizes on symptom improvement when compared to control participants that were on a waitlist for treatment (Reynold et al., 2012). While effects immediately post-treatment have shown moderate effects, it is crucial to note that long-term treatment effects of psychotherapy for depression among adolescents are modest (0.21; Echstain et al., 2020). The varied effect sizes for treatment continue to highlight the need for innovative approaches to the mental health of children and adolescents. In addition, while the metanalyses demonstrate small to large effects for psychotherapy delivery to children and adolescents, data are limited to the children and adolescents who access treatment. Consequently, metanalyses exclude youth

who do not have access to treatment, and therefore have unmet mental health needs that have not been adequately studied.

Disparities in Adolescent Mental Health

Unmet mental health needs affect all youth. About 75% of youth, regardless of ethnic and racial background, experience unmet mental health needs (Interagency Working Group on Youth Programs, 2018). Unmet mental health care needs can have potentially negative repercussions such as the development of subsequent and more severe symptom presentations that may cause functional impairment (Andrew et al., 2001; Kessler et al., 2005). While it is true that all youth experience limited access to mental health supports, it is well known that youth with minoritized identities and/or youth facing systemic problems (e.g., limited access due to geographical location, poverty, limited transportation) experience mental health concerns at elevated rates while also experiencing less access to care. The US Department of Health and Human Services (2021) shared current data of disparities and access to mental health treatment of adolescents in the United States. Thirty-one percent of White youth receive mental health services in comparison to 13% of youth of color. White youth are more likely to receive mental health treatment and Asian youth are the least likely (Mental Health America, 2022). Among adolescents with major depression, Black adolescents were notably less likely to speak to a mental health professional and seek mental health support when compared to their non-Hispanic White peers (Cummins & Druss, 2011). Overall, although White youth still experience mental health concerns at an increasing rate, it is evident that youth with minoritized identities are not accessing treatment at the same rates. Despite persistent and well documented disparities in mental health, inequities continue to be an overwhelming concern and area of improvement for the field of psychology. It is possible

that innovative youth engagement strategies for mental health prevention and promotion programs can have a positive effect in addressing disparities prior to youth needing access to individual therapeutic care.

Youth Engagement in Mental Health

Adolescence is a developmental point when youth are engaging with peers at a much higher rate, practicing independent decision-making, and seeking autonomy, making it a unique developmental phase to consider when thinking about optimizing engagement in mental health programming. Additionally, adolescence is a critical point of prevention and intervention given that puberty is a biological milestone that affects behavior, social-emotional wellbeing, and lifelong health (Sawyer et al., 2012). Environments that create opportunities for adolescents to engage in decision-making and autonomy can positively impact health-related behaviors (e.g., substance use, interpersonal connectedness; Sawyer et al., 2012; Scales et al., 2000). Incorporating developmental assets, such as decision-making power, autonomy, and importance of peer relationships, into mental health programming may influence youth's engagement in proactive behaviors (e.g., seeking mental health services when necessary, sharing information with peers) in their mental health.

In order to facilitate teen access to mental health treatment, it is important to understand barriers and facilitators to their engagement. Radez et al. (2021) conducted a systematic review of 53 quantitative and qualitative studies that reported barriers and facilitators to youth seeking help from a mental health professional. In their review, Radez and colleagues (2021) found that youth do not seek treatment for a variety of reasons, such as lack of knowledge of signs and symptoms of mental health, not knowing how to access services, a perception that mental health treatment may not be effective, mental health

stigma, and previous bad experiences with mental health professionals. Their findings highlight areas of improvement, such as increasing knowledge of symptoms, reducing stigma, and providing information of how to access treatment, that can be addressed through effective strategies that target mental health knowledge and engagement. A review that aimed to understand effective youth engagement strategies highlighted that treatment strategies that prioritize youth engagement are especially effective in establishing relevance for youth (Sawyer et al., 2012). Some of the recommendations include creating systems that appreciate the importance and specificity of adolescence as a developmental stage, developing prevention interventions that exist beyond the health sector in order to support youth in their various environments targeting risk and protective factors, creating health systems or intervention programs that include greater engagement of youth and their voice, and encouraging youth to use their voice in identification of their health and solutions (Sawyer et al., 2012). In alignment with these recommendations, engaging youth within mental health promotion and prevention programs can serve as a crucial intervention point to provide ample benefit during adolescence.

Youth Centered Programs

Youth-centered programs within health interventions are associated with improved outcomes of treatment and likelihood of participation (Garnick et al., 2012; Garvey et al., 2006; Hawke et al., 2019). For example, including multiple services (e.g., housing information, mental health services, medical care) in a youth-serving agency contributes to youth's feelings of safety and increases likelihood of program participation in the various services available to youth (Muir et al., 2012). While centering services in a youth-serving location (e.g., teen center, schools) can be helpful for integrating care and increasing access,

Hawke et al. (2019) highlighted that having youth included in the development of the program and implementation is critical since they are the most well positioned to determine if a program is tailored for youth. A 2017 systematic review exploring strategies to engage youth in mental health treatment found that youth engagement in the development of mental health services, delivery, and evaluation encourages the development of coping and professional skills (Hawke et al., 2018). Thus, in creating mental health promotion and prevention programs, it is critical to incorporate youth centered programming efforts.

Mental Promotion and Prevention Programs

Mental health promotion can be defined as, "intervening to optimize positive mental health by addressing determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving the positive mental health of the population." Prevention efforts aim to minimize mental health problems with the ultimate goal of reducing mental health problems in a population (youth.gov, nd). Much of the research for mental health promotion programs has been conducted in school settings (Fenwick-Smith et al., 2018) and more recently, in primary care settings (Budd et al., 2020). For example, there is ample research that highlights how school-based mental health promotion programs that encourage resilience, self-awareness, self-efficacy, and help-seeking behavior have positive impacts on academic achievement, behavior, mental health symptoms, and social and emotional skills (Dray et al., 2017; Weare & Nind, 2011). Barry et al. (2013) conducted a systematic review of 22 randomized control trials (RCTS) and quasi-experimental studies that explored the effects of mental health promotion programs in low- and middle-income countries for participants between the ages of six to 18 years old. Authors found that including mental health promotion programs in community-based programing

demonstrated moderate to strong effects, particularly in making positive impact on youth mental health and social wellbeing (Barry et al., 2013). A metanalysis of 177 universal prevention studies, found effects ranging from 0.24 to 0.93, depending on the program and population (Durlak & Wells, 1997). Together, promotion and prevention efforts may be effective in reducing the increasing demand on the mental health care system and supporting communities *before* the need for individual mental health care services. While mental health promotion and prevention efforts have been effective in school and primary care settings, there is an opportunity to expand to additional spaces where youth and families occupy and find community.

Mental Health Promotion Programs in Community Based Organizations

Mental health promotion and prevention efforts in Community Based Organizations (CBOs) can offer an opportunity for programs to reach youth and communities in a location they are *already* routinely attending and reduce the burden of seeking programs in a different location, ultimately making programs more accessible. CBOs are core spaces in communities that have a long history of providing access to social services (e.g., food, housing, childcare, recreation) while also being an essential component to after school care for youth. Additionally, researchers have highlighted that engagement in services may be perceived as more accessible and less stigmatizing given that enrollment in community organization is not contingent on insurance payment, legal documentation, or language proficiency (Rusch et al., 2015; Rusch et al., 2020). In a scoping review, Hawke et al. (2019) found that including various services in youth-serving agencies are believed to make youth feel safe in accessing services, and as a result, increasing engagement in services. Taken together, the availability

of multiple services in CBOs has the potential to increase availability of mental health promotion programs, especially for marginalized communities.

Efforts to integrate mental health promotion and prevention programs into CBOs has been highlighted as a necessary step to serve communities. Additionally, implementing promotion and prevention efforts in CBOs aligns with the World Health Organization's (WHO) comprehensive mental health action plan for 2013 – 2030, which aims to improve mental health by strengthening integrative and responsive community-based care through promotion and prevention strategies (WHO, 2021). While research related to mental health promotion programs within CBOs remains limited, there is some research that focuses on the benefits of mental health programs within CBOs, specifically for Latinx immigrant families. Rusch et al. (2020) developed the Family Mental Health Advocacy (FMHA) approach with a goal of incorporating programming that provides parenting support and skill-based learning, to ultimately impact positive youth outcomes through CBO staff-led programming. FMHA focuses on two key components, 1) training CBO staff on immigrant related stressors and mental health, and 2) engaging CBO staff to provide supportive listening and collaborate with families to develop advocacy skills to identify needs, set goals, and implement action plans (Rusch et al., 2020). Given the success of programs like FMHA, it is possible that similar strategies that specifically target adolescents may also be successful. Moreover, given the accessibility and reduction in barriers to CBOs (e.g., insurance payment, community space), it is critical that the field of psychology consider ways to integrate promotion and prevention programs in CBOs that specifically target adolescents.

Literature that focuses on using youth engagement strategies and youth centered programming to build mental health promotion interventions for adolescents within CBOs is

limited. Due to this limited area of research, I developed the YPEAM program. Positive Youth Development (PYD) and Youth Participatory Action Research (YPAR), along with current literature related to psychotherapy treatment, youth engagement strategies, and prevention and promotion programs, were used to develop YPEAM. The conceptual framework is presented in the next section.

Conceptual Framework

PYD and YPAR are the two main frameworks that have influenced the development of YPEAM. PYD is an umbrella term that incorporates concepts from various disciplines with a common goal of increasing access to relationships, programs, settings, and activities to ultimately promote healthy youth development (Benson et al., 2006). Researchers have attempted to distinguish PYD through the following three features that influence holistic youth well-being. First, PYD aims to target ecological contexts that include neighborhoods, relationships, families, schools, and communities. Second, PYD promotes experiences and supports, such as programs that build skills, advocacy, and prosocial involvement that ultimately contribute to the well-being of youth. Third, PYD encourages the use of promotion methods to increase youth access to experiences, resources, and opportunities that can facilitate positive developmental outcomes (e.g., self-efficacy; Benson et al., 2006). The wide-spread use of PYD has proven to be successful in developing policy solutions and system changes that promote bonding, resilience, social competence, emotional competence, self-efficacy, positive identity, and opportunities for prosocial involvement (Benson, 2006). PYD is also considered a core component of YPAR. YPAR focuses on PYD components by centering youth's strengths, agency, and promotes protective factors. YPAR and PYD can

serve as an intentional step to counter adult-generated, problem-centered narratives associated with youth (Lanhout & Thomas, 2010).

YPAR challenges the traditional notion of knowledge creation and the "expert" role in research (Cammarota & Fine, 2010). YPAR was originally developed as a research framework to engage youth, as co-researchers, exploring and creating novel ways to address issues that directly impact them (Rodriguez & Brown, 2009). Rodriguez and Brown (2009) proposed three YPAR principles, which are 1) YPAR is inquiry-based and aims to challenge traditional notions of knowledge creation by honoring lived experiences, 2) YPAR provides a framework for intentional participation in the project, and 3) YPAR is transformative for youth and aims to change systems from the perspective of youth needs. YPAR has consistently shown to have positive effects on youth, such as increased agency, leadership, academics, critical consciousness, and interpersonal skills (Anyon et al., 2018). PYD and YPAR present a strong foundation on how to better approach adolescent mental health needs in a way that is youth centered.

YPEAM builds from these existing interrelated frameworks. Using YPAR and PYD as guiding frameworks for mental health promotion programs can allow youth to advocate for their mental health needs and contribute to mental health interventions that are flexible to their social context. Although there has been literature that highlights the effectiveness of YPAR in various settings (see Anyon et al., 2019; Linqusit-Grantz, 2020; Valdez et al., 2020), YPEAM proposes an innovative adaptation of the YPAR framework to support engaging youth in a novel mental health promotion program. While the principles of YPAR were used as a framework for the creation of the curriculum, the present study differs from YPAR implementation because youth are not situated as co-researchers.

Youth Participatory Engagement and Action in Mental Health

In line with PYD and YPAR, YPEAM was created as a method for encouraging the following: 1) the promotion of youth assets, such as lived experiences, social context, and strengths, and their incorporation into teaching and learning the curriculum; 2) fostering and supporting participating youths' agency through their contribution to the curriculum, increased knowledge of mental health treatment plans, and insight into developing solutions to improve mental health systems; and 3) enabling youth-attended environments through peer bonding, youth-responsive services, and encouraging youth-centered approaches to health. The overarching goal of YPEAM is to enhance mental health knowledge, reduce stigma, and increase youth engagement in a mental health promotion program through PYD frameworks and promotion strategies.

In creating a curriculum-based intervention, informed by PYD and YPAR, I believe there may be various benefits at the individual- and community-level. The intention of the curriculum is that by increasing youth's mental health literacy and reducing stigma, youth will shift their perspective on seeking mental health treatment and ultimately seek treatment as they best see fit. Similar to YPAR, in that youth are taught about basic research methodologies before implementation and analysis of their research, YPEAM may present a scaffolding opportunity for youth to feel more comfortable seeking treatment with the basic mental health knowledge presented throughout the YPEAM curriculum. Additionally, the curriculum-based intervention may offer communities the opportunity to implement their own adaptation of YPEAM to best support the community's needs. Due to the curriculum-based model, it is possible that YPEAM may be implemented by lay community members

and further expand its accessibility and sustainability across various settings in the community.

The rationale for a mental health promotion program, such as YPEAM, was motivated by the following four areas of literature. One, while mental health treatment has proven to be somewhat effective in improving youth mental health outcomes, it is limited to youth who are *enrolled* in treatment, consequently not providing any understanding of the value of treatment for youth who are not receiving treatment. Two, data clearly demonstrates that marginalized youth have less access to treatment and prevention programs. Three, CBOs have a long history of providing social services in an environment that often has less barriers for care (e.g., not needing insurance), which has shown to be particularly beneficial for marginalized communities. Lastly, researchers have highlighted the benefits of prevention and promotion programs that can be implemented in community settings (e.g., CBOs, schools). While there is extensive literature on the four areas of research, there remains a gap in the literature on mental health promotion programs that specifically target adolescents and leverage their developmental assets of decision-making, autonomy, and peer connection. I created YPEAM as a mental health promotion program with the guidance of two existing frameworks, PYD and YPAR, that leverage developmental assets in programming.

Study Purpose

The present study aims to determine the feasibility and acceptability of YPEAM as a mental health promotion intervention. Feasibility studies aim to understand components of intervention implementation (data collection, recruitment), delivery (feasibility), and social validity (acceptability) to inform future, larger-scale implementation studies, to then determine efficacy of the proposed intervention. Pilot studies are an important step in

understanding the feasibility of novel or new applications of interventions (Leon et al., 2011). This project also explores outcomes from youth participants related to mental health literacy, stigma, and attitudes towards mental health. The results have implications for improvements and modifications of YPEAM that can be made prior to implementing YPEAM on a larger scale. The following research questions were used to guide this study:

Research question 1: How feasible is YPEAM delivery within a youth community setting?

1a. How feasible was youth participation in a semi-manualized intervention (i.e., transformative, participatory, inquiry-based)?

Research Question 2: How acceptable is YPEAM within a youth community setting?

2a: How satisfied were youth post YPEAM intervention?

2b: What feedback did youth provide about the curriculum and program?

Research questions 3: How did participation in YPEAM affect youth outcomes?

3a. Was there a difference in mental health literacy after youth participated in YPEAM?

3b. How did participation in YPEAM affect youth's attitudes towards mental health (e.g., stigma, perceived effectiveness)?

Chapter II: Methodology

YPEAM was tested using a pre-test post-test convergent mixed methods design to explore the feasibility, acceptability, and outcomes of implementation at a community-based youth organization. A convergent mixed methods design was used to obtain different but complementary data. The convergent mixed methods design includes four steps: 1) collecting quantitative and qualitative data, 2) analyzing quantitative and qualitative data separately and independently through their own analysis procedures, 3) comparing qualitative and quantitative data by using a table or narrative discussion, and 4) interpreting the data to determine the ways in which the data differ, relate to each other, and/or come together to create a better understanding of the study's goal (Creswell & Clark, 2017). Table 1 presents how the qualitative and quantitative data were used to answer each of the three research questions. Data collection methods and procedures will be explained in the sections to follow.

Table 1

Research Questions Aligned with Data Collected

Research Question	**Quantitative Data**	**Qualitative Data**
1a. How feasible was youth participation in a semi-manualized intervention (i.e., transformative, participatory, inquiry-based)?	Attendance & Dosage	Semi-structured Interview data: Curriculum (Their experiences with the ability to change the curriculum)
2a. How satisfied were youth post YPEAM intervention?	Acceptability Survey	Semi-structured Interview data: Learning about mental health in a group setting with peers
2b. What feedback did youth provide about the curriculum and program?	No quantitative data collected for research question 2b	Semi-structured Interview data: Curriculum (Any feedback on the curriculum)

3a. Was there a difference in mental health literacy after youth participated in YPEAM?	No quantitative data collected for research question 3a	Module pre- and post-surveys Mental Health Literacy Components
3b. How did participation in YPEAM affect youth's attitudes towards mental health (e.g., stigma, perceived effectiveness)?	Mental Health Stigma Pre- and Post- survey responses	Semi-structured Interview data: Barriers to Mental Health (Stigma, cost)

Design and Procedures

A flow diagram is included in Appendix A to provide a detailed visual on procedures of administered surveys throughout the implementation and evaluation of YPEAM.

Recruitment and Participant Selection

Youth participants were recruited from a youth community center. This center was selected based on a previously established relationship through a university-community partnership with the dissertation chair. There were four primary methods of recruitment. One, adult partners from the youth center made a general announcement about YPEAM presenting it as one of the options for their after-school programing. A script designed to give a general overview, review of compensation, and disclosure of mandated reporting requirements of the group facilitator was shared with adult partners. Two, I shared a flyer that was placed on the front desk of the youth center for youth and parents to access. Three, adult partners called the parents of youth who fit the age criteria (i.e., 12 – 17 years old) to notify them about this new opportunity. Calling parents to notify them about new programs was typical practice for this youth center. Fourth, on a separate occasion, I visited the youth center to be available for questions, build rapport with students, and hand out parent/guardian consent forms to the students who expressed interest and met the age criteria. Materials regarding the intervention (i.e., the curriculum outline and main concepts taught for each module), data collection

methods, and tentative dates and time were sent home to parents/guardians with the consent forms (see Appendix C). After students returned the signed parent/guardian consent forms, students were asked to sign a youth assent form via Qualtrics. Consent and assent forms included consent for participation in the YPEAM program and post-implementation semi-structured interviews (see Appendix C).

Participant selection was based on group fit and size as decided in collaboration with the adult youth organization leaders. Group fit was determined by the age of participants and their availability to attend the sessions. Our recruitment efforts resulted in nine consented youth. One youth dropped out of the program while the remaining eight students participated for most sessions and surveys. Of the eight youth who remained in the program, mean age was 15.12 with a range of 13 – 17 years old. The majority of youth (n = 5) identified as Latinx, one participant identified as Asian, one other as White, and one youth as mixed descriptors that included White and Latinx. For gender identity, seven youth identified as male, and one youth identified as female.

When recruiting youth, it was important to understand participants' previous experience with mental health knowledge, given that mental health knowledge is a measured outcome. When asked if they had a parent who was a mental health professional, zero students responded "yes." Four youth self-reported as having received mental health services in the past, while the remaining four youth had never received mental health services. It is possible that participants who have a caregiver in the mental health field, or if they have previous mental health experience, they may be entering the program with a baseline level of mental health knowledge. Prior knowledge and experience of mental health was not an exclusionary factor, but an important factor to consider when understanding data. Youth were

compensated $15 per session and $15 for their semi-structured interview. The study procedures were approved by the University of California, Santa Barbara institutional review board.

Setting and Apparatus

YPEAM was conducted in a youth community center located in southern California. I, as the creator of YPEAM, implemented the program at a local youth center that provides after school programming for youth between the ages of 9 – 18 years old. All participants attended local public schools and routinely presented to the community center for their afterschool programming. Each session of the program was held in a private space to maintain group rapport and allow for organic discussion amongst youth and facilitator.

YPEAM: The Intervention Program

YPEAM implementation consisted of thirteen hour-long group sessions that were divided into six modules. Table 3 provides an overview of the sessions within each module. Each module has one to two sessions and is intended to be flexible to group needs and their social context. For example, if students prefer to spend more time in module two prior to proceeding to module three, facilitators can adjust the delivery of the curriculum. Additionally, if there is a unique need in the community (e.g., substance use), facilitators may change sessions that are not considered "core" modules to match the expressed needs.

I developed YPEAM as a novel mental health promotion program for youth between the ages of 12 – 17 years by adapting Rodriguez and Brown's (2009) three main YPAR principles, which are 1) YPAR is inquiry-based and aims honor lived experiences, 2) YPAR provides a framework for intentional participation in the project, and 3) YPAR is transformative for youth and aims to change systems from the perspective of youth's needs.

YPEAM (Larez, 2024) is inquiry-based by way of allowing for flexibility in the curriculum so that it is better aligned to their social context and individual and community needs. The participatory framework in YPEAM are threefold: 1) It allows youth to change modules as they see fit, and potentially create their own modules that are reflective of their needs, 2) youth can challenge existing modules of the curriculum and offer feedback for future implementation, and 3) YPEAM can be transformative in its implications for practices within the community organization, can offer a curriculum-based approach to mental health in various settings, and can offer a youth perspective on how the field of psychology engages youth mental health to potentially shift how we work alongside youth. Importantly, YPEAM is an intervention that is intended to move the field of psychology towards youth-driven rather than adult-driven practices. Youth-adult partnerships is an intentional practice that establishes equity between young people and adults (Ramey et al., 2017). YPEAM provides a manualized and participatory approach to mental health promotion interventions that encourages youth-adult partnerships in hopes of scaffolding towards youth-driven mental health interventions.

Table 3

Module and Outline of Activities for each Module

Module	Activities
1	Intro: Orienting Youth to Curriculum & Participatory Components Intro: Rapport Building Activities Activity 1: Mental Health and Mental Illness Activity 2: What is trauma?
2	Activity 1: Defining stigma Activity 2: Substance Use and Mental Health Activity 3: Community perceptions about Mental Health, Mental Illness, and Substance use Activity 4: Reducing Stigma

3	Activity 1: Common mental health symptoms and mental illness in adolescents Activity 2: Mental health and mental illness in media Activity 3: Cultural considerations of mental health symptom presentation
4	Activity 1: Learning about common treatment modalities Activity 2: What do I do in therapy? Activity 3: Barriers and Facilitators to people accessing mental health (social determinants of mental health) & how we can help
5	Activity 1: Coping Mechanisms Activity 2: Building a treatment plan Activity 3: Building a local resource list Activity 4: How to access local resources
6	Activity 1: What does healing look like in your context? (Community healing) Activity 2: Understanding resilience and post-traumatic growth + reviewing coping mechanisms Activity 3: Celebration – should take up the whole last session

YPEAM Delivery

YPEAM was delivered between January – March 2023. For this pilot implementation of the YPEAM curriculum, I was the facilitator and creator of the curriculum, and two research assistants consulted for the creation of the curriculum, took attendance, and observed the implementation. Prior to the implementation of YPEAM, research assistants were given an overview of the procedures and when tasks were to be completed (i.e., attendance, tracking survey completion, and payment) and tracked on an excel sheet. I was present at all 13 sessions across seven weeks. The curriculum was delivered twice a week on Tuesdays and Thursdays. The research assistants alternated on what day they were present for implementation of the curriculum, due to their availability. The present undergraduate student observed and recorded data (e.g., attendance, payment).

Data Collection

Demographic Survey

A simple demographic questionnaire was developed for this study and was administered during the first session of YPEAM. The questionnaire included questions specific to participants' age, grade, gender, race/ ethnicity, if they had previous mental health experience (e.g., seeing a therapist), and if they had a parent/ caregiver who a mental health professional. The questionnaire is included in Appendix C.

Research Question 1: Feasibility

Feasibility is the concept used to capture if an innovation (i.e., YPEAM) is possible, which involves understanding if something can be done, barriers and facilitators to implementation, and how to move forward (Eldridge et al., 2016). Attendance, dosage, and consent rates of recruitment efforts were the quantitative components used to understand feasibility. As recommended by Berkel et al. (2011), attendance and dosage were measured as two separate participant behaviors. Attendance is defined as the number of sessions the participants attended, from the available sessions they could attend (e.g., one participant joined halfway through the program). Although there is variation regarding the definition of dose and dosage in the literature, for this study dosage is defined as the amount of intervention received (Rowbotham et al., 2019). Consent rates were defined as the percentage of students who participated in YPEAM and provided written assent/consent after the initial interest point (i.e., the recruitment from adult partners) out of the available youth within the age range at the center.

Interviews and Memos

Qualitative data for feasibility was informed by semi-structured interview data and memoing. For feasibility, qualitative data were gathered to understand youth's perspective on the curriculum and barriers and facilitators to implementation within their CBO. Semi-structured interview procedures are explained at the end of the methodology section given that semi-structured interviews informed all three research questions. Of the eight youth who participated in the YPEAM program, all eight participated in the semi-structured interviews. Interview questions can be found in Appendix C.

Regarding memo practices, the facilitator and undergraduate research assistants wrote memos throughout the process. Memoing practices were guided by Birks et al. (2008), which highlights the various ways to use memoing, such as recording the decision-making processes from conceptualization to completion, examining and meaning making out of data, documenting how the researchers' perspectives impact interpretation of data, and maintaining open communication between team members and stakeholders. I, as the lead researcher, used memoing throughout the process to understand implementation barriers and facilitators, note any communication with the director of the community center, document any changes to research activities and methodologies, and facilitate the analysis of data. Research assistants were trained on memoing practices prior to analyzing qualitative interviews. They were asked to write memos after each interview they analyzed, and memos were shared with the lead researcher after each interview. Research assistants were provided a template that included questions about major themes, any similarities or differences they were noting, and any important quotes from participants. Memos were used in understanding any changes to

the code book that were necessary, reconcile differences in codes, and understand how each of our identities were influencing the analysis of the interviews.

Research Question 2: Acceptability

Acceptability is used to determine whether implementation of a program was appealing to its participants (Lancaster et al., 2004). Youth participants completed a short questionnaire with the following items: *I like/ was pleased with the YPEAM mental health knowledge program, I would suggest participating in this program to friends or other youth, I think it is a good idea to provide young people with mental health knowledge programs in teen centers, most youth would find the program implemented in your teen center appropriate*. Youth responded to the questions on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." Importantly, this questionnaire has not been validated and therefore, items from the questionnaire were adapted and not used as a unified scale. Acceptability questions were adapted from Lindow et al. (2020), whereby authors implemented a youth suicide prevention program in a school setting.

In regard to qualitative data, youth participants completed a survey and participated in a semi-structured interview. The survey included the following open-ended questions: *What do you believe were the most important parts of the YPEAM program (please write freely); In your opinion, what else could be done to help young people discuss their mental health concerns; Is there anything else you would like to say?* At the end of the YPEAM program, youth also participated in semi-structured interviews to determine the acceptability, their perceived effectiveness of the mental health promotion program, and any feedback they had for the program.

Research Question 3: Outcomes

Mental Health Stigma

As a quantitative component, the barriers questionnaire from the Adolescent Mental Health Support Scale, with an alpha coefficient f 0.88 for reliability, was used to measure mental health stigma (Green et al., 2021). The scale asked participants to respond to seven statements related to their mental health. For example, "Even if I had problems, I would be too embarrassed to talk about it." Respondents then had a choice to select from a four-point Likert scale, "strongly disagree" to "strongly agree." Researchers created the scale by conducting focus groups and incorporating feedback from school personnel and adolescent students. Given that the original scale developed by Green et al. (2021) was used for school settings and has verbiage specific for school setting (e.g., seeing a school counselor), I adapted some of the items to be reflective of the community youth center setting. For example, the original scale stated, "I don't know who to go to for help at school," and we adapted the question to state, "I don't know who to go to for mental health support." Additionally, I removed one question as it didn't fit the setting, which made the scale a 9-question scale instead of a 10-question scale as originally developed. A higher score indicates more perceived mental health stigma with a score range between nine and 45. Mental health stigma was only measured using quantitative data, however mental health stigma was a main component of outcomes measured for this study.

Mental Health Literacy

To assess the mental health literacy of YPEAM participants, a survey was administered at the beginning and end of each module. Each survey asked questions that reflected learning objectives in the module. For example, in module three, questions included

(a) What are the most common mental health disorders for youth your age, (b) what are some common symptoms of these, and (c) how do you think culture influences mental health? Pre-post module qualitive surveys were not coded, rather raw data were presented for each participant and are presented in Appendix A. Additionally, coding that categorizes based on theory, in this case mental health literacy core components, was used to identify themes in the semi-structured interviews. For the purposes of this study, the following definition of mental health literacy was used: "knowledge that benefits the mental health of a person or others including, knowledge of how to prevent a mental disorder; recognition of disorders when developing; knowledge of effective self-help strategies for mild-to-moderate problems; and first aid skills to help others," (Kutcher et al., 2016, p.32).

Interview Procedures

The two research assistants, with previous experience conducting interviews, were the interviewers for the post-implementation interviews. I trained the research assistants on the protocol prior to the interviews with participants. Training included reviewing the materials, reading, and discussing theory related to feasibility, acceptability, and outcomes (i.e., stigma, mental health literacy) during weekly research meetings. We also practiced the interview questions during research meetings to discuss any needed changes to optimize interview structure. Interviews were conducted in a room with a door at the community center to ensure privacy and the quality of audio. The interviewers used semi-structured interview protocols that were focused on five main sections: (a) their overall experience as youth participants in YPEAM, specifically focusing on components of acceptability, (b) mental health literacy and how they might explain it to another person, (c) perception of stigma, for example how they perceive mental illness, (d) perception of seeking mental health support

and how to find support, and (e) any additional topics that arose during implementation of the YPEAM curriculum, such as access and what "ideal" mental health support would look like. The full interview protocol can be found in Appendix C.

The interview protocol was designed to capture qualitative information for each research question (i.e., feasibility, acceptability, and outcomes related to stigma and mental health literacy). Table 2 outlines which theories guided each part of the protocol and how they align with the research questions. Feasibility was defined as any feedback or conversation from participants that informed if YPEAM should be continued to be implemented, understanding barriers and facilitators, and suggestions made on how to move forward (Eldridge et al., 2016). Acceptability coding was guided by Lancaster et al. (2014)'s definition of determining if participants liked or disliked the implemented program. We used the following definition of mental health literacy:

> "…knowledge that benefits the mental health of a person or others, including knowledge of how to prevent a mental disorder; recognition of disorders when developing; knowledge of effective self-help strategies for mild-to-moderate problems; and first aid skills to help others. Deductive data analysis includes examining a subset of codes that are aligned to youth engagement strategies, components of mental health literacy, and mental health stigma (Kutcher et al., 2016)."

For help seeking behavior, we used Barker's (2007) definition which states that help seeking behavior is any action or behavior taken by an adolescent when they perceive the need and can include formal support (e.g., counselors, therapists, medical staff, faith leaders, youth programming) or informal support (e.g., family, friends).

Table 2

Interview Protocol Sections Aligned with Research Questions and Theory

Research Questions	Interview Section	Theoretical Guidance
Research Questions 1 & 2: Feasibility and Acceptability	Experience	Eldridge et al., 2016; Lancaster et al., 2004
Research Question 3: Outcomes	Mental Health Literacy	Kutcher et al., 2016
Research Question 3: Outcomes	Stigma	Kutcher et al., 2016
Research Question 3: Outcomes	Seeking Treatment	Kutcher et al., 2016; Barker, 2007
Questions were added as part of the iterative process after several interviews	Additional Questions	Maxwell, 2012

Aligned with the iterative process of qualitative methods (Maxwell, 2012), we modified the interview protocol as team members found it necessary (e.g., wording of the question was unclear). After the first three interviews and realizing that the interviews did not last for the intended duration of 30 minutes, we added two additional questions so that youth had more opportunity to expand on these areas. These questions were, “How do you think knowing information about mental health influences your perception on mental health services?” and “ If you were to need or want mental health services, do you feel like you would know where to go for help? ” In interviews seven and eight, we also prompted youth participants to discuss how components of their identity (e.g., gender, sexuality, immigration status, racial and ethnic background) affect their perception of mental health. Interviews were transcribed using Otterai or NVivo, depending on what was available to the transcriber.

Research Team

I, as the dissertation author, am a Latina cisgender heterosexual female who grew up in a low-income family along the US-Mexico border and was a first-generation college student. At the time of this study, I was a fourth-year doctoral student conducting my dissertation research. One of the undergraduate researchers is a White cisgender heterosexual male. At the time of the study, he was an undergraduate student in psychology. The second undergraduate researcher is a Black, cisgender, heterosexual female. At the time of the study, she was an undergraduate studying sociology, dance, and applied psychology.

Qualitative Analysis

Reflexive Thematic Analysis (Braun & Clarke, 2006; Braun & Clark, 2019) was used as the analytic approach for the semi-structured interviews. Throughout our coding process, we followed reflexive processes, which Braun and Clark (2019) defined as the intentional process of working within the intersectionality of data, analysis, and researchers' subjectivity and identities. As a research team of three, the two undergraduate students conducted the interviews, and the three research team members completed the analysis. Throughout the process of coding, we maintained weekly team meetings to discuss any variations and reconcile disagreements about coding. During weekly team meetings, we also discussed how our identities affected our understanding and analysis of youth's narratives, guided by Braun and Clark (2019). No major concerns were raised throughout the coding process.

Within reflexive thematic analysis, we specifically employed a *theoretical* thematic analysis that consisted of coding based on a specific research question, in this case, theoretically driven codes related to feasibility, acceptability, and outcomes of youth participants (i.e., mental health literacy, help seeking behavior, stigma). Feasibility was

defined as any feedback provided by participants that highlighted barriers and facilitators or informed how to move forward with the curriculum and program (Eldridge et al., 2016). Coding for acceptability was informed by Lancaster et al., 2004, which is any responses that indicated if participants liked, disliked, or recommended the program. Outcomes were defined by Kutcher et al., 2016's definition of mental health knowledge, which highlights several components of mental health literacy, such as being able to recognize symptoms in self and others. Codes were then mapped on to the existing theories. For mental health knowledge, subthemes were used to capture each component of the definition (i.e., recognition of symptoms of mental health disorders, self-help strategies, and skills to help others). For Barker's (2007) definition of help seeking behavior, which includes any action taken to seek mental support, the research team decided to add a modification that includes any intent to carry out help seeking behavior as part of our theoretical codes.

For the analysis, we maintained weekly research team meetings and analysis plans to ensure consistent review of the data. First, two research team members transcribed four interviews, either via Nvivo or Otterai, and wrote memos highlighting any themes they found and notable quotes from the interviews. The graduate student read all transcripts and memos and created a working draft of the code book. We all then coded the first two interviews and created an exhaustive list of themes and shared our findings at the weekly meeting, originally identifying five themes (i.e., mental health literacy, group setting, curriculum, barriers to help seeking behavior, and facilitators to help seeking behavior). We then worked independently to code an additional two interviews with the working draft of the code book and again, shared our findings and discussed any disagreements at the weekly meeting. At this stage, we decided to refine our code book to only four themes. We removed "facilitators to help

seeking behavior" given that it was similar to the help seeking behavior sub code that we included under mental health literacy and would be better understood as a component of mental health literacy. We also decided to decide to rename the "group setting" code to "learning setting" given that we felt it better encompassed the broader understanding of what youth were expressing that they enjoyed about the program. After this meeting and reconciling any differences in codes, each team member individually coded the remaining four interviews prior to the next team meeting. At the next meeting, we continued to discuss coding alignment. Additionally, while research assistants were not blinded to the identity of each interview they were transcribing, I, as the creator and facilitator, was not aware of the identity of interview transcripts.

Chapter III: Results

Aligned with the convergent mixed methods design of this study, quantitative and qualitative results are presented under each research question. However, themes that were identified in semi-structured interviews are presented in Table 4 and will be further discussed in relation to each research question. We identified four major themes that aligned with the research questions (i.e., curriculum, learning setting, barriers, and mental health literacy).

Table 4

Research Questions Aligned with Qualitative Themes and Subthemes

Research Question	Qualitative Theme	Subthemes
Feasibility	**1. Curriculum**	1.1. Their experiences with the ability to change the curriculum.
Acceptability	**1. Curriculum**	1. 2. Feedback about what they liked and didn't like
	2. Learning Setting	2.1 Learning about mental health in a group setting with peers
Outcomes	**3. Barriers**	3.1 Feelings related to stigma, such as negative connotations related to seeking help 3.2 Perceived cost of mental health services
	4. Mental Health Literacy	4.1 Knowledge about mental health and its benefits 4.2 Knowledge and ability to identify mental health symptoms/signs 4.3 Knowing and feeling comfortable how to find resources for mental health support 4.4 Engaging or intention to seek support from formal or informal support 4.5 Intent to help others with gained knowledge

Research Question 1: Feasibility

Quantitative Results

Quantitative measures of feasibility included attendance, dosage, and consent rates of recruitment efforts. Per program director report, there were 11 youth who met the age requirement (i.e., 12 – 17 years old), that regularly attended the teen center for after school programing. All 11 youth were approached by the youth center adult partner to assess initial interest to participate in YPEAM. Of the 11 youth, 81% (n=9) of the youth received parental consent and provided youth assent. Of the nine youth who provided consent and assent, eight engaged in the sessions consistently, attended until the end of the program, and completed the post-implementation interview. One youth dropped out of the study after they provided assent. There was a total of 13 YPEAM sessions. Dosage and attendance rates are shown in Table 5. Overall, attendance was very high, however, dosage (i.e., number of sessions) for each youth participant varied. Since the initial consent, James' mother spoke to me to share that he would only be able to attend once a week, which resulted in attending six of 13 sessions. Sam joined about halfway through implementation. He was approached by a peer from the group, who asked him if would be interested in joining. Given that youth participation and voice is a core component of YPEAM, I asked the rest of the youth participants if they would like to approve of Sam joining the group. The youth agreed to incorporate Sam into the remaining sessions. Sam then obtained consent and assent and attended the remaining seven sessions of YPEAM.

Table 5

Youth Participant's Attendance and Dosage

Student	Attendance	Dosage in number of sessions completed

Bobby	100%	13
Yesenia	100%	13
Andres	100%	13
Anthony	100%	13
Cesar	100%	13
Juan	92.31%	12
Sam	100%	7
James	100%	6

Qualitative Results

Qualitative data for feasibility included coded data from the individual semi-structured interviews and memo data with notes regarding any barriers, facilitators, and solutions to implementation of YPEAM.

Experiences with Changing the Curriculum

To answer research question 1: How feasible was youth participation in a semi-manualized intervention (i.e., participatory, inquiry-based, transformative), youth participants expressed varied views on their perceived ability to change the curriculum (i.e., the participatory component). For example, one student requested that we replace one of the lesson plans with a lesson on suicide signs and prevention given his own life experiences with this topic. Other students also favorably reflected on the change, “when [name of youth] added like, suicide. Like made me want to learn more about it. Like, different ways to stop suicide from happening.” In addition to students reflecting on requests from their peers, one student noted that they appreciated the ability to change the curriculum, “I would tell them that it's a very like, educational pathway towards learning anything you want to know about mental health. And like, I don't know if they would get to choose like we did, the modules.

But that was, that's a nice freedom to have." In terms of transformation of systems around them, youth shared suggestions and feedback to shift implementation of the program and how mental health promotion programs are implemented within their community organization. For example, one youth suggested that there should be a parent component, "I feel like it would be beneficial if parents like saw a program and to see like, what it would mean to have a therapist for your child." Youth suggesting a similar program for parents will have implications for the future of YPEAM and similar programs.

Data from Memo Journal

Aligned with mapping research activities through memoing (Birks et al., 2008) and considering the elements of feasibility as explained by Eldridge et al. (2016), which aim to understand the barriers and facilitators to implementing a project, I detail important insights that I noted throughout development, approval of IRB, and implementation of YPEAM. Barriers to implementation primarily included considerations related to working with minors. Aligned with my values and dedication to creating more equitable ways to incorporate youth participation within research, I wanted to pay youth participants for their time. However, the IRB committee illuminated ethical concerns about paying youth participants, especially under the age of 15, to participate in a mental health promotion program. In addition, they also shared concern about safety measures in place in the case that youth may felt particularly vulnerable in the context of discussing mental health topics. Each of these concerns were reasonable, notable, and helpful, and as a result, shifted how I planned to implement the program, which is important for feasibility. After discussion with the IRB committee, we agreed that paying youth $15 per session, rather than per hour, would be allowable. To address their concern about safety, I included scripting regarding my

responsibility, as a clinician and a mandated reporter, prior to implementation of the curriculum. While YPEAM is not intended to be group therapy, it did discuss mental health topics, which led the IRB to encourage me to include additional safety precautions at the beginning of implementation. The director of the community center agreed with changes to implementation that were not originally presented to him. These changes caused a delay in implementation of YPEAM. Considering these elements prior to future iterations of YPEAM are important, as they impacted the feasibility of implementation.

Facilitators to implementation included three primary components. First, the university- community center partnership was facilitated, in part, by my dissertation chair's existing relationship with the director of the youth community center. This allowed for a smooth introduction to the community partner and in some ways, an existing trust in the relationship, which may have contributed to his trust in the YPEAM program. Second, the community partner had just been awarded an external grant that required that they have a deliverable of programming that included some component related to mental health and substance use education. In conversations with the community center director, this led me to add a lesson into the curriculum related to substance use. Importantly, as a clinical practicum student, I had experience in substance use treatment that informed my lesson planning. Lastly, an additional facilitator to the implementation of YPEAM within the community center was that I had previous experience in facilitating group sessions with youth. This informed my recruitment decisions, such as playing basketball and board games with youth in the center to build trust prior to asking students if they wanted to participate in YPEAM. From my previous experiences with youth, it was necessary to establish some level of trust to enlist their engagement in the program.

Research Question 2: Acceptability

Quantitative Results

To measure satisfaction of the program and curriculum we gathered data via a short anonymous survey. A total of five youth completed the acceptability survey. All youth liked the program with three respondents responding, “strongly agree” and two responding “agree.” For question two (i.e., I would suggest the program to friends) and three (i.e., I think it is a good idea to provide mental health knowledge programs in teen centers) three youth responded with, “strongly agree” and two with “agree.” When asked if most youth thought would the program appropriate to be implemented in a teen center, four youth responded with, “agree” and one responded, “strongly agree.” For the feedback survey responses (n = 7), when youth were asked what they felt the most important part of the program was, the most common response (n = 5) was related to learning about mental health or mental health resources.

Qualitative Results

Feedback on the Curriculum and Program

To qualitatively gather data on acceptability, including feedback, we asked youth about their general experience with the program during their semi-structured interviews. Youth noted that some of their least favorite parts were, “Sharing some personal things,” “Maybe not being interactive or not listening,” and “Sometimes it felt all the surveys felt repetitive. And felt like we were talking about the same thing over and over again.” Students also noted that the curriculum or something similar could be used for other occasions and settings.

> “I mean, I feel like it would be beneficial if parents saw a program like this and to see what it would mean to have a therapist for your child, what it means to pay for that kind of stuff.”
>
> “I say the program is good. I feel like it should be passed on in high school. Like [in] high school, they do say it, but they don't go really into depth like you guys do. Yeah, like you guys help us understand.”

The community partner director provided curriculum considerations, which ultimately contributed to the acceptability of YPEAM as an afterschool program. He noted that the curriculum should not feel like students are in class given that YPEAM would be an after-school program and students would not want to be in a setting that felt like a classroom. One of the youths reflected on their experience in regard to this consideration and stated,

> “It was very welcoming, and it wasn't super like, they obviously… like the topics were serious and like, other times, you need to pay attention, but it wasn't like, it didn't really feel like, it wasn't like a class or something. You know, it just kind of felt like a normal discussion. So, I would say that was probably the best part.”

Several youths indicated that their favorite part of the curriculum was learning in a group setting and being able to share the experience with peers. Some youth shared that it was helpful for them to learn from other people’s experiences. One youth participant noted, “I guess my last thing I want to say is that doing this kind of stuff really helped me a lot. I got to see a point of view of other people and their problems that matter, it will help me help a lot of people.” From these data, it appears that an important element of the YPEAM program is that group delivery of the curriculum and prioritizing peer relationships was something that sustained their approval of the program.

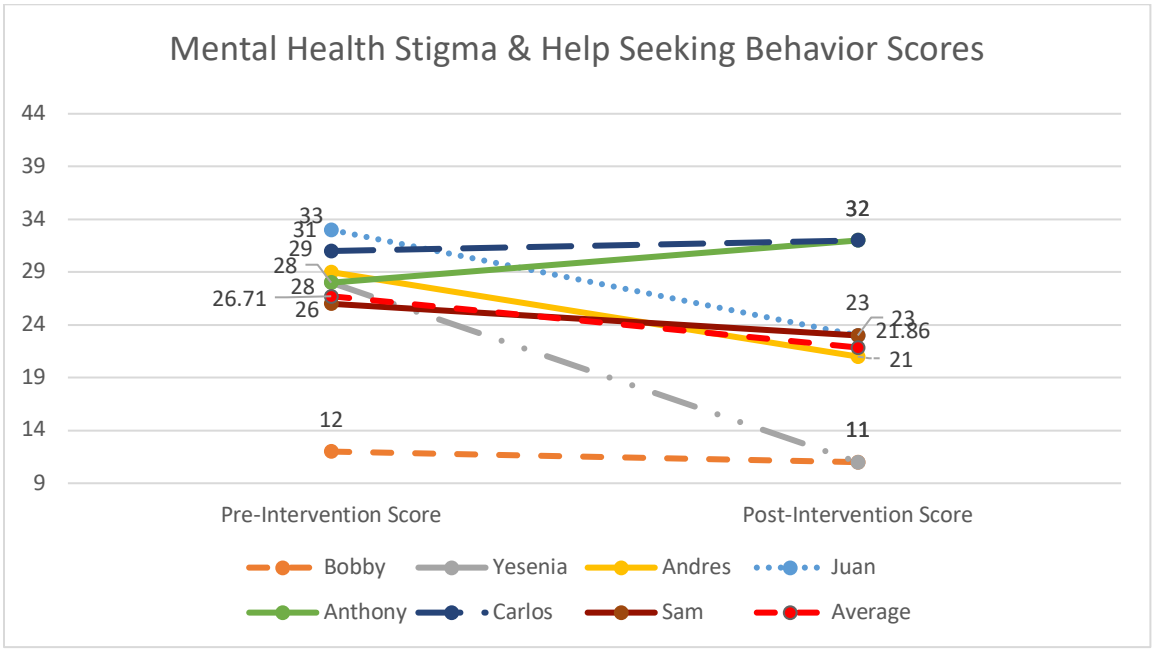
Research Question 3: Outcomes

Quantitative Results

Mental health stigma scores were reverse coded as recommended by the authors of the questionnaire (Green et al., 2019). One youth's scores were not included in the analysis of mental health stigma scores given that he was not present for the first or last session. Pre- and post- YPEAM mental health stigma scores were compared and discussed using only descriptive statistics given the small sample size. Results from the pre-survey (M = 26.71, SD 6.87) and post-survey (M = 21.86, SD = 8.61) indicated a notable (18%) decrease in the group average (M = - 4.86, SD = 7.24). Understanding the group mean difference allows me to understand the group impact, however, individual differences were also noted. Figure 1 demonstrates the individual differences in raw scores amongst the seven youth participants and the average score for pre- and post-YPEAM program implementation.

Figure 1

Mental Health Stigma & Help Seeking Behavior Scores



Qualitative Results

Qualitative data results yielded data for two research areas of interest for outcomes of youth who participated in YPEAM, 1) Mental health stigma, and 2) Mental health literacy.

Mental Health Stigma

In addition to quantitative results of mental health stigma, qualitative data revealed multiple instances of stigma in youth's narrative experiences. Some of their experiences related to cultural influence, and others reflected on peer perception.

> "I guess, like Mexican culture… And when I was raised, I was taught to be more closed off about my emotions, and not try to talk to people. And like, had that perception of me being strong and just trying to uphold that image."
>
> "Because I've heard a lot of kids my age, they don't really appreciate anything because they don't think it's, I guess, technically cool. And then they have been scared of what other people would think."
>
> "I mean, I feel like a lot of teenagers don't really see [a therapist] because they feel like they would get shamed for it. So, I feel like people got to wake up and realize, like, you know, it's not cool to do that to people."

As demonstrated in the quotes, some of the expressed concerns were related to the social perception of peers, however youth also provided recommendations that peers should not "shame" others when there is knowledge that they are seeing a therapist. In addition to perception of mental health, two students mentioned cost as a barrier to accessing mental health services.

Mental Health Literacy

In addition to the pre and post open-ended surveys for each module, we gathered qualitative data responses from semi structured interviews. A table of pre and post open-ended survey responses for each module and participant can be found in Appendix C. Qualitative data from youth's semi structured interviews are presented based on the following definitions of mental health literacy and help-seeking behavior: Knowledge about mental health and its benefits, knowledge and ability to identify mental health symptoms/signs, knowing and feeling comfortable how to find resources for mental health support, engaging or intention to seek help from formal or informal support, and intent to help others with gained knowledge (Barker, 2017; Kutcher et al., 2016).

Knowledge about Mental Health and its Benefits. One of the most prominent themes in the data is youth sharing their reflections about learning about mental health and its benefits. While their examples were not always specific, they noted their confidence related to knowing about mental health.

> "…just being able to learn more, and I guess it could be being more aware of everything they taught us. Even just the little things that I didn't think were tied to mental health. I just think I feel better, like, knowing that there's more to it. I know more about mental health."

In addition to their qualitative feedback about knowing more, youth also had an opportunity to explain mental health. When asked how they would describe mental health to others, several youths noted some of the following responses, "healthy mind," "reflecting on your feelings," and "health of the mind and how it can affect your actions, behavior, and mood." Notably, one of the youth interviewees did refer to specific lesson plans when

reflecting on their learning experiences and mentioned learning about addiction, psychology generally, and suicide prevention. Two youth also shared their reflections on mental health knowledge being a helpful tool to share with other peers.

> "Like, making sure that people know what certain things are, and even, recognize it and then they know what to do. So, I guess if they need that knowledge, they'll have it."

This youth was also referencing to sharing the information on the resources they gained from YPEAM, with peers in other settings. The theme of knowing about mental health and its benefits, was frequently paired with other subthemes, such as gained knowledge of mental health resources and their intention to help others. Youth frequently spoke about not only their experiences with mental health but also their school peers' and family experiences.

Knowledge and Ability to Identify Mental Health Symptoms. Nearly all youth mentioned that they were better able to recognize symptoms of common mental health presentations (e.g., depression, anxiety) either for themselves or their peers and family members. For example, one teen recalled one of their experiences with friends in the school setting.

> "Some friends would come up and talk to me about, you know, I guess, just being all like different, because usually they're really energetic and nice and stuff. And they come up to me some and then all of a sudden, they act totally different and have a different energy."

For them, this experience stood out as an occurrence where they made the connection between what we talked about in lessons to their real-world experience (e.g., depressive

symptoms). Other youth recognized symptoms in themselves, while also recognizing that they need professional help for a formal diagnosis.

> "I think it helped me realize what are some emotions that I felt and some of like connections to some of the mental health terms. I shouldn't diagnose myself, but usually I remember back then I don't know, a lot of social anxiety. I really didn't like talking to people."

Similar to the subtheme of knowledge about mental health, several youths reflected on their confidence about being able to identify symptoms but were not always specific and instead shared reflections like, "But after this, knowing more about mental health, made me more comfortable around that topic. I feel like I could identify more signs." As demonstrated above, their ability to identify symptoms amongst themselves and others varied, however it is important to consider qualitative results for the outcomes of this study.

Knowledge and Comfort about Mental Health Resources. Most students discussed their level of comfort with accessing resources or discussed resources in the context of sharing them with others. On various occasions, youth participants highlighted the value of sharing resources with their peers and family members. One of the activities within the curriculum tasked students to contribute to a mental health resource guide for their local area, which allowed them to share a resource guide with others. Youth also discussed their experience searching for resources throughout their interviews. For example, a few students reflected on the websites that were part of the resource guide and mentioned that they felt comfortable doing their own research on other mental health resources. While the websites from the resource guide were mentioned by youth during their interviews, other youth

thought of YPEAM as a mental health resource. For example, when they were reflecting on YPEAM, one youth mentioned how mental health promotion programs can benefit others.

> "Especially if they have other friends that they think could be going through something or is affected by mental health. I'd say it [YPEAM] helps to find resources, or just to learn more in general."

While this theme is less prominent in the data, it is one that was frequently mentioned with the intention to share their gained resources and knowledge with their peers.

Engaging in Help Seeking Behavior, Intention, and Comfortability. While coding for help seeking behavior and intent, it was evident that youth sought, or felt comfortable seeking support through various formal (e.g., counseling services) and informal (e.g., friends and family) mechanisms. Others noted their level of comfort in seeking help if they found it necessary in the future, "I guess, like I said, more comfortable with mental health. More, since you guys explained it, like better than what I had in mind, and different forms of therapy, made me more open to the idea of seeking help." This youth respondent noted that having knowledge of different therapeutic techniques contributed to their help seeking intent. Several youths reported that they would seek help at help school due to proximal access and others due to their perception of school counselors being more comfortable with youth issues. A couple of youth shared their reflections on when they would seek mental health services in the future.

> "I think yes, the reason would be like, it's better to have the help instead of like dealing with a situation that you don't know how to deal with. Yeah. Like, let's say you're feeling down, like not motivated to do anything like it feels weird. And then like at that point, I would actually search for help."

> "Well, before I didn't really know about mental health. But, after I came to this program, it really showed me that if I ever do go through anything like this, to seek help, like, right away."

As demonstrated in the quotes above, youth respondents noted that their perceived severity of symptoms would contribute to their decision to seek help.

Intent to Help others with Gained Knowledge. Intention to help others was a prominent theme in the data. When youth respondents mentioned helping others, it was often tied with another subtheme. For example, youth respondents highlighted the value of gaining resource knowledge to share with peers.

> "I have more resources and stuff. Like if a friend needs help, I know where they can get help [and] what I can help them with. If they need help, I can help them reach out to someone to tell them about a program or help them find any program like that could help them."

Youth interviewees found that recognizing symptoms was a key gained skill that they can use with friends. One youth respondent noted, "I guess, maybe that I need to notice things more. Watch out for signs that friends and family have. So, I feel like it made me more, be more like, watchful, I guess." Being amongst their peers, generally, was also a motivating factor to participating in the YPEAM program. Amongst all sub themes, youth interviewees often highlighted the benefits, not only for themselves but for those they often come in contact with.

Chapter IV: Discussion

The purpose of this study was to evaluate the feasibility and acceptability of implementing the YPEAM program within a youth organization. In addition, we examined pretest and posttest youth outcomes related to mental health knowledge and stigma. This pilot study was guided by a convergent mixed methods design, in which quantitative and qualitative data were used to provide different but complimentary results. In summary, feasibility and acceptably resulted in favorable findings for implementation of YPEAM. In terms of quantitative youth participants outcomes, pre- and post-test mental health stigma surveys indicated an average decrease of 4.5 points, with a range of 9 – 45, amongst youth participants. Qualitative results for outcomes highlighted youth's experiences in gaining mental health knowledge and their perception of mental health generally. Their experiences with the program revealed how mental health promotion programs may not only positively contribute to an individual's mental health literacy but also benefit their interpersonal relationships (e.g., peers, family). In this chapter, I discuss the feasibility, acceptability, and youth outcomes of YPEAM implementation and related literature, along with strengths and limitations of the study, and lastly, implications for future research and practice in this area. Qualitative themes are discussed under their specific research questions.

Research Question 1: Feasibility

Quantitative (i.e., consent rates, attendance, and dosage) and qualitative (i.e., memos, semi-structured interviews) results suggested that YPEAM was feasibly implemented in a youth community center. For this study, high rates of attendance, dosage, and consent rates indicated positive implications for feasible implementation. Data from memos, as well as discussions with the community organization director, highlighted that youth participation

was driven by two factors: 1) YPEAM was integrated into a setting they were already frequently attending prior to the implementation of this project, and 2) youth were paid for their time. The benefit of including multiple services and resources within one setting that families may already be attending, such as a CBO, has been highlighted in literature as a potential method to increase accessibility and engagement in resources, in particular for marginalized communities (Hawke et al., 2019; Rusch et al., 2015; Rusch et al., 2020). Including YPEAM in an already trusted and frequented setting, as well as compensating youth, appear to be key components for feasibility of YPEAM implementation. While there is limited research on the effects of monetary incentives in recruitment efforts, some researchers have found that paying youth is more effective than alternative rewards (Afkinich & Blachman-Demner, 2020; Nguyen et al., 2014). It is possible that payment of youth participants may contribute to reducing the power imbalances between youth and adult partners, which is particularly important when trying to innovate strategies on how to increase youth engagement for program implementation.

As an additional component of feasibility, I was interested in understanding youth perspectives on the curriculum. Participant interview data provided complimentary qualitative data that suggested youth generally had a favorable view of the curriculum. Specifically, some youth noted they appreciated the ability to change the curriculum to match what they wanted to learn more about. Youth changed the curriculum two times throughout the implementation of YPEAM. In considering why more youth did not take advantage of the flexibility, it is possible that they perceived the flexibility as a positive component of the curriculum but were unsure how to navigate it given that youth are not often given decision-making power in their frequented settings (e.g., schools, hospitals). In a review of barriers

and ethical challenges with YPAR, Kim (2016) identified that unequal power relationships often impeded full participation of youth in research. While YPEAM did not situate youth as researchers, it is likely that similar barriers, such as unequal power relationships between youth and me as the facilitator, did impact their ability to fully take advantage of the flexibility of the curriculum. However, one youth noted that even though she didn't request any changes to the curriculum, "it was a nice option to have," suggesting that *knowing* about the flexibility may be contributing to the feasibility of implementing flexible curricula for youth in other settings.

Taken together, quantitative, and qualitative data contributed to my understanding of next steps of the implementation, including the barriers and facilitators of implementation with the youth center. While high attendance rates provided quantifiable findings that demonstrated how *often* youth attended sessions, the qualitative data helped me understand *why* youth agreed to participate in the novel program. The qualitative data informed their high attendance rates. For example, data highlighted that their high attendance rates were motived by the ease of access of YPEAM within their community center and monetary compensation as a primary factor of attending and completing the surveys. Interpreting qualitative and quantitative data to determine how the data relate to each other and come together created a better understanding of the feasibility of YPEAM, which is in line with the goals of a convergent mixed methods design (Creswell & Clark, 2017).

Through the memoing process I tracked research activities that highlighted that YPEAM may not be feasible to be implemented by lay community members. Initially this curriculum was created with the intention that it would be able to be delivered by non-mental health professionals that have greater access to youth (i.e., religious youth leaders, teachers,

community organization staff). However, after implementing YPEAM, I found that my skills as a psychology graduate student with clinical experience was used to inform discussions and lessons that students requested. For example, when students had questions about suicide prevention strategies and wanted to include a lesson on the subject, I referred to my graduate training on suicide screening and best practices for prevention amongst teens. In addition, during the lesson plan for substance use, I referred to my clinical experience working with individuals who were receiving treatment for medical detox from substances. While there is information in the curriculum to support implementation for folks who do not have mental health training, I believe that it was necessary to provide additional information during discussion with peers that was not structured into the curriculum. Therefore, it is possible that other models, such as community health worker models (e.g., promotoras), may be more appropriate for future implementation.

Research Question 2: Acceptability

For quantitative data, youth participants completed an anonymous acceptability survey at the end of YPEAM implementation. Questions included: *I liked/ was pleased with the YPEAM mental health knowledge program, I would suggest participating in this program to friends or other youth, I think it is a good idea to provide young people with mental health knowledge programs in teen centers, most youth would find the program implemented in your teen center appropriate*. A total of five of the eight youth who participated in YPEAM completed the survey. Participants rated the above questions on a 5-point Likert scale from, "strongly disagree" to "strongly agree." Youth participants provided overwhelmingly positive feedback as demonstrated by all responses being either "agree" or "strongly agree." Youth interview data complemented the overwhelmingly positive quantitative results by expanding

on details and suggestions from acceptable implementation of a program like YPEAM. For example, two youth participants suggested that YPEAM be implemented within school settings and incorporated a parent component, which speaks to their favorable perspective of the program. While they shared that their school already has a mental health component, they shared the importance of going into details of mental health knowledge.

Qualitative results for acceptability were twofold, 1) youth provided feedback about their favorite and least favorite parts of the curriculum implementation, and 2) youth shared their experience with the learning setting of YPEAM. Youth shared that some of their least favorite parts were sharing personal stories and the repetitive nature of the lessons. Youth expressed that they enjoyed that it didn't feel like they were attending a class where they had to engage in activities, such as homework. Our results may be explained by previous research that explored youth satisfaction of after-school programming, which found that programs, such as sports, arts, and academic enrichment program, were amongst the programs where youth reported the highest rates of positive affect and satisfaction. Alternatively, youth's perceptions of engaging in homework was associated with lowest reported affect, low intrinsic motivation, and low levels of engagement (Shernoff and Vandell, 2007). While YPEAM is not considered an academic enrichment program, it has similar components, such as youth and adult partnership in activities centered on learning content. Therefore, it is possible that these components contributed to youth's positive impression of YPEAM, especially when considering that they felt that it didn't feel like a classroom.

Researchers also hypothesized that afterschool programs that include opportunities for peer engagement, such as sports and group academic enrichment programs, may be experienced as positive because of the autonomy and peer engagement components (Shernoff

and Vandell, 2007). In their individual interviews, youth respondents often noted the importance of peer relationships as motivation to join and continue in YPEAM. Research has consistently demonstrated that peer relationships become of critical importance during adolescence and therefore, have a significant influence on youth's well-being, perspectives, and attitudes (Brown and Larson, 2009). In the context of YPEAM, peer relationships were a strong component that influenced uptake of the program and consistent attendance for youth given that peers within the youth community organization often encouraged each other to attend.

Research Question 3: Outcomes

Aligned with systematic review findings that explored most frequently reported barriers to mental health care amongst adolescents, our pilot study aimed to target two primary barriers: stigma and mental health literacy (Radez et al., 2021).

Mental health Stigma

Quantitative results indicated an average group decrease, of about five points, in mental health stigma scores post-YPEAM program. While evaluating mental health stigma, it is important to consider the demographics of my sample. DuPont-Reyes et al. (2020) conducted a linear regression analysis comparing adolescent views on self-reported mental illness stigma through an intersectional lens that highlighted differences in perceptions among Latino boys, Latina girls, non-Latino (NL) Black boys, NL- Black girls, NL-White boys, and NL-White girls as the reference group. While they used a different measure of mental illness stigma (i.e., vignettes of youth with mental illness), findings may have important reflections for the YPEAM pilot study outcomes given that my study sample consisted of one student who self-identified as an Asian male, one White male, five male

Latinx youth, and one female Latinx student – that is, the majority of my sample were Latino males ranging from 13 – 18 years old. While the authors identified unique patterns at the intersection of ethnicity, race, and gender in their sample, authors underscored that generally, boys of color (i.e., NL-Black boys and Latino boys) reported more behaviors associated with higher levels of stigma (e.g., less knowledge/ positive attitudes, greater avoidance/ discomfort; DuPont-Reyes et al., 2020). However, the study did not take into consideration how structural barriers have influenced how Black and Latino boys receive social messaging about emotional well-being and mental health.

Qualitatively, youth in our sample, discussed how culture and peer relationships impacted their perception of mental health (i.e., stigma) which complemented the quantitative data results. In the YPEAM sample, the intersection of gender identity and culture, in this case Mexican culture, was discussed in youth interviews. For example, a male identified Latinx youth participants shared the following anecdote:

> "I guess, Mexican culture. When I was raised, I was taught to be more closed off about my emotions, and not try to talk to people and like, had that perception of me being strong and like, just trying to uphold that image."

Throughout the sessions, there were many discussions about how culture, ethnicity, gender, and age influenced how youth participants perceived accessibility to mental health, their own mental health, and mental health stigma within their family structures. Individual mental health stigma scores also highlighted the intersection of ethnicity, gender, and age. For example, the two youth participants' whose mental health stigma scores increased on their post-program survey were both male, in middle school (13 and 14 years old), and Latinx. These data align with previous research that found that among 274 eighth graders,

male participants had less mental health knowledge and higher rates of mental health stigma (Chandra, A., & Minkovitz, 2006). Taken together, research from Chandra and Minkovitz (2020) and DuPont-Reyes et al. (2020), which indicated higher rates of mental health stigma among boys of color, may explain the two youth whose mental health stigma scores increased following YPEAM implementation. However, during one of these youth's semi-structured interviews, he shared that YPEAM helped him feel more equipped to manage his emotions, and therefore, contributing to his belief that he no longer needed therapy and indicating on the mental health stigma questionnaire, that he would not seek mental health support – contributing to a higher score post YPEAM implementation. This qualitative input suggests that reduced need, not stigma, explained the increase in scores for the Latino males in the YPEAM sample. As exhibited by these youth, quantitative and qualitative data were crucial in understanding the influence of culture, ethnicity and race, gender, and mental health stigma results.

Given that culture, ethnicity, and gender were frequent conversations during YPEAM, it is important to consider my own identify as the facilitator. Upon reflecting about my own identities while facilitating YPEAM sessions, it likely that these discussions were influenced by my identity as a cisgender female within the Mexican culture, which personally have influenced how I have perceived mental health structures. While not measured, it is possible that discussing my own identity, as well as sharing my lived experiences with the youth, may have contributed to youth engagement and acceptability of the program. Research has indicated that having staff, with similar lived experiences as the youth, increases youth engagement and participation in programming (Dune et al., 2017). I openly discussed my

identity with youth participants which may have influenced their ability to discuss their identity, mental health beliefs, and culture.

Mental Health Literacy

Mental health Literacy was only evaluated qualitatively and included five subthemes: 1) knowledge about mental health and its benefits, 2) knowledge and ability to identify symptoms, 3) knowing and feeling comfortable seeking mental health resources, 4) engaging or intention to seek support from informal or formal supports, and 5) intent to help others with gained knowledge. Overall, youth expressed that they felt more confident with their knowledge about mental health. Pre and post open-ended question surveys for gained knowledge specific to each module can be seen in Appendix A. However, youth responses to these pre and post module surveys did not include many specific examples and youth expressed that they didn't think the surveys were necessary. It is possible that a quantitative survey, with multiple choice questions related to learning objectives, may have been more effective in measuring gained knowledge for each module. Below, I present qualitative results for each subtheme for mental health literacy.

Knowledge about Mental Health and its Benefits

In a systematic review of barriers to accessing mental health services among youth under the age of 18, researchers found that in 53% of their studies, young people reported that not knowing about mental health (e.g., symptoms, how to access, where to find services) was a major barrier (Radez et al., 2019). YPEAM aimed to target some of these gaps in knowledge for our sample. In the semi-structured interviews, seven of the eight youth discussed topics that aligned with knowing about mental health and its benefits. In addition, various youth noted that they appreciated the in-depth review of basic information about

mental health. While the present study did not measure mental health symptoms, it did target mental health literary which may have important implications for prevention. Lam (2014) conducted a population-based survey among adolescents and found that mental health literacy levels were associated with depression levels amongst their sample and suggested that mental health literacy may be an important intervention target for youth's well-being.

Knowledge and Ability to Identify Symptoms

Several youth participants reported feeling more confident in their ability to recognize symptoms in themselves, family, and peers. Identification of symptoms amongst peers is a particularly positive outcome of this study given that peer-to-peer identification and support of mental health concerns has shown to reduce stigma. Our findings are consistent with Parikh et al. (2018), which revealed that in their peer-to-peer depression school awareness program, youth reported increased confidence in identifying and referring peers to support for depression, improved help-seeking intentions, and a decrease in stigma. Therefore, peer relationships can be catalysts to positive youth outcomes that are associated with better mental wellbeing and developing youth engagement strategies can continue to contribute to positive peer spaces. Along with gained confidence in identifying symptoms and knowledge, youth also felt more comfortable seeking resources.

Knowing and Feeling Comfortable Seeking Mental Health Resources

Data for this subtheme was limited given that youth responses were not specific, and therefore likely not as effective. However, youth did share a general feeling of comfortability of searching for resources online, especially following the lesson where youth co-created a list of community resources that was then distributed back to them at the end of YPEAM. Minimally improved resource knowledge following YPEAM, as a mental health promotion

program, is similar to other research findings with comparable goals. For example, Lindow et al. (2019) found small, statically significant increases in recourse knowledge, in a sample of more than 400 youth, in Montana and Texas. Notably, Lindow et al., (2019) used quantitative measures to assess for resource knowledge, which differs from how resource knowledge was assessed for in YPEAM. However, each of these studies have important implications for efforts to increase resource knowledge. With minimally improved effects for both, it is likely that different methods should be considered to target resource knowledge specifically.

Engaging or Intention to Seek Support from Formal or Informal Support

Youth expressed more willingness to seek support at the end of YPEAM, however qualitative data were not specific. Importantly, there was one youth who expressed that he did not think he would seek mental health services following YPEAM. In his interview, he further explained that he felt that YPEAM gave him basic skills to manage his emotions, and he may have perceived YPEAM as a support itself. While this was an unintentional outcome, it does contribute to our conclusion that mental health literacy can be a useful prevention method for mental health psychopathology. Importantly, youth interview data revealed varied forms of seeking support, both through formal (e.g., counselors, therapist) and informal (e.g., parents, peers, teachers) support persons, with more preference given to informal persons. This is a particularly positive result from our study given that willingness to seek support from informal services has shown to decrease depressive and anxiety symptoms (Sheeber et al., 1997). However, it is possible that youth who are comfortable seeking support from peers and family, may also have a supportive social environment which likely contributes to lower levels of depression and anxiety.

Intent to Help others with Gained Knowledge

Intent to help others with gained knowledge was one of the subthemes that youth discussed most frequently. Similar to the benefits of peer-to-peer identified symptoms discussed in the second subtheme, intent to help others with gained knowledge is an important indicator of mental health literacy (Kutcher et al., 2016, p.32). Several youths noted that they wanted to share their resource list, created during YPEAM, with peers and family members. Youth participants' willingness to share about mental health knowledge is an important finding given that widespread knowledge of mental health literacy can have positive affects for stigma reduction. Various studies have found that discussing mental health experiences or sharing information about mental health contributes to lower levels of social stigma related to mental health conditions (Bulanda et al., 2014; Lindstrom et al., 2021). Given that adolescence is period where youth are spending more time with their peers and seeking autonomy, it is crucial for mental health promotion programs for teens to encourage peer-to-peer resource and knowledge sharing.

Strengths and Limitations

The present study has various limitations. The primary limitation of this study is that there were not multiple groups to evaluate effectiveness of a treatment group and a control group as there would be in a randomized pilot study (Eldrige et al., 2016). Having more participants would have strengthened this study. As Brown (1995) recommended, a pilot study sample size is guided by the general rule of thumb for 30 participants, which was not the case for the present study. Limited sample size was partially due youth availability within the community center. There were only 11 youth that fit the age criteria (i.e., 12 – 17 years

old), which ultimately limited the sample. It is likely that including YPEAM in an additional youth serving CBO would have strengthened the results.

An additional limitation related to acceptability is that the survey was only completed by one stakeholder (i.e., youth participants). Proctor et al. (2011) recommended that acceptability should be measured from various stakeholders. In the case of YPEAM, parents and the community program director could have contributed to a better understanding of the acceptability of YPEAM with the community center setting. An additional methodological flaw is that not every sub-research question (i.e., 3a. Mental health Literacy) had quantitative and qualitative data that informed outcomes, which would have been more aligned with the convergent mixed method design of this study. Better alignment of quantitative and qualitative measures should be considered in future pilot studies of mental health promotions efforts. Overall, the convergent mixed methods design was crucial in understanding the feasibility, acceptability, and outcomes of this study.

Additional limitations are related to the demographic make-up of the sample. While it is racially and ethnically diverse, all youth self-identified as cis gender and able-bodied at the time of this study – demonstrating clear gaps in sampling. Age of participants may also be a limiting factor. For example, youth who were still in middle school (13-year-olds, n=2) often contributed to the discussion and activities less when in comparison to those in high school (14 – 17 years old, n=6). An additional complication that arose with an age criterion with middle and high school students was that the IRB had more concerns about payment of middle school youth when compared to high school students, which ultimately shifted how I compensated youth. When I originally created this curriculum, I was hoping to sample only high school students given my previous experience discussing mental health topics with high

school aged youth, which originally motivated this project. However, the community organization director shared that obtaining at least 10 youth within 14-18 years old would not be feasible given the age demographics of the youth center. With this knowledge, I decided to shift my age criteria to 12 – 17 years old.

Finally, while this study was intended to allow for youth decision-making in shifting the curriculum, it was not used to the level I anticipated when creating the curriculum. Youth were aware that they could request changes in the curriculum, however, only two youth requested a change. I suspect this was due to various reasons, such as youth not being used to shifting curriculum in school settings and I could have incorporated it as an expectation that they would suggest at least one new lesson for each module. Although youth did not shift the curriculum as much as I anticipated, flexibility was a favorable aspect that youth appreciated and suggested to maintain as a key component of future it

While this study has various limitations, there are notable strengths. The primary strength of this study is that it is the first mental health promotion program, to our knowledge, that explicitly incorporates youth decision-making principles informed by PYD and YPAR. Consistent with youth engagement strategies that previous research has indicated to positively impact the uptake of mental health programming (Sawyer et al., 2012), YPEAM was intentional about leveraging developmental assets (e.g., autonomy, decision-making) and included decision-making power as a core component of the curriculum. Flexibility and youth decision making components of this curriculum are a particularly notable strength given that youth diversity should be considered in implementation of mental health promotion programming. For example, it is possible that this curriculum can be implemented for specific groups of youth (e.g., LGBTQ+ youth, rural youth, immigrant youth) who may

benefit from more tailoring of the curriculum that reflects strengths and specifically considers oppressive systems that affect their communities. By using PYD and YPAR frameworks, it is possible that we can capitalize on youth's developmental needs, such as increased opportunity for decision-making power and peer relationships, while also tailoring the curriculum to address specific challenges faced by groups of youth.

An additional strength of this study is the diversity of the sample. While it was not intentional to seek a sample that was majority male identified (n = 7), it is important to note as a strength given that male adolescents have lower rates of help seeking behavior (Liddle et al., 2021). Additionally, the majority of the YPEAM sample were from marginalized groups (i.e., Latine or Asian), which is a strength given that sampling in psychological research remains majority White (Cheon et al., 2020; Romida, 2022). It is likely that the diverse sample was a result of the setting of the youth community center location. Generally, California has a large population of Latiné people with about 40% of its population being comprised of Hispanic/ Latiné people (census.gov) which may be contributing to the sample of the present pilot study. Additionally, the location of the community youth organization is also in an area where many Latiné families live and attend nearby schools. The last strength related to sampling is that we were able to reach a consent rate of 72.7% of available youth within the age criteria. It is possible that this rate is due to recruitment efforts but also pre-existing peer relationships where youth encouraged each other to join YPEAM.

Implications for Research and Practice

This study demonstrated the importance of focusing on youth engagement strategies to improve positive youth outcomes. Given that youth engagement strategies have been underscored as a best practice in public health and health promotion programming by the

Center for Disease Control (2010), it is critical that future research and future mental health promotions programs consider the strengths and limitations of the present study. Youth engagement strategies, such as including PYD and YPAR as frameworks in the creation of mental health promotions programs, are still emerging in research. YPEAM can serve as a model for continued research efforts in this area. Feasibility and acceptability outcomes provide information for better implementation in the future. Future iterations of YPEAM should (a) consider the availability of youth within a youth community organization that fit the desired age range, (b) ensure compensation of youth participants given the positive impact it had on recruitment for this pilot study, and (c) apply recruitment efforts that include youth recruitment of other peers (i.e., snowball sampling).

Future research should implement similar mental health promotion efforts that explicitly include youth decision making and center positive youth engagement strategies. However, larger samples and a control group may be necessary to assess outcomes more accurately. Additionally, youth decision making, such as ability to change curriculum demonstrated in YPEAM, may benefit from revisions so that youth capitalize on this opportunity. I suggest future iterations to set the expectation that youth suggest or change at least one lesson through each module. Focusing on youth decision making is an especially important strategy to focus on for future research, given its success on positive youth outcomes (Anyon et al., 2019; Sawyer et al., 2012; Valdez et al., 2019). Thus, researchers should consider how programming, methods of implementation, and youth-adult partnerships can be shifted to center youth as decision makers.

In future implementation efforts of this curriculum, it is likely that a model that trains lay community health workers as facilitators may be better suited for the delivery of

YPEAM. Originally, the intention of YPEAM was that it could be feasibly implemented by any adult community member (e.g., religious leaders, teachers, coaches), however after implementation, I realized that at least basic mental health knowledge of the facilitator may be necessary to answer youth follow-up questions during lessons. Training lay community health workers, like Promotoras¸ which are trained lay health professionals that are commonly seen in public health work in Latiné populations, may facilitate optimal expansion and ensure that the delivery of mental health information is being shared from a professional. Previous studies found positive effects on mental health outcomes with implementation of a community-based mental health promotion program that was led by Promotoras (Tran et al., 2013). Using a lay community health worker model may allow for youth to continue asking questions related to mental health. Efforts to increase capacity-building for lay staff members to implement programing within CBOs is a burgeoning area of research that may support future mental health promotions program efforts within these settings (Rusch et al., 2015; Rusch et al., 2020). Additionally, it is possible that similar strategies, at the peer-to-peer level (e.g., Parikh et al., 2018), may also be beneficial in future iterations.

Summary and Conclusions

Various health care associations have called for specific attention for child and adolescent mental health given the increasing concern of prevalence across the United States (US Department of Health and Human Services, 2021). Importantly, while increased mental health needs are evident for all youth, there are clear disparities that indicate that youth from marginalized backgrounds demonstrate higher need and access services at a lesser rate (Interagency Working Group on Youth Programs, 2018). In addition, while calling for more attention to child and adolescent mental health is important, there are notable limitations to

current treatment methods. Effects of individual psychotherapy for adolescents have demonstrated various levels of effectiveness, highlighting the need for innovative strategies to support the mental health of adolescents (Echstain et al., 2020; Kazdin et al., 1994; Reynold et al., 2012; Weisz et al., 1995). Taken together, the need for innovative programs to 1) increase accessibility to mental health programming and services, especially for marginalized youth, and 2) create mental health promotion programs that are available prior to the need for individual psychotherapy, is an important opportunity for intervention for child and adolescent mental health.

Exploring effective strategies to create innovative mental health prevention and promotion programs that specifically target youth may have positive impacts for their wellbeing. Targeting mental health prevention efforts during adolescence is crucial, given that 75% of life-time mental illness develops before the age of 24 (National Alliance of Mental Health, 2021). Research has identified various barriers and facilitators to youth accessing treatment and mental health programs, such as low perceived need, limited mental health knowledge, and stigma (Radez et al., 2019). We explored literature that highlighted effective youth engagement strategies, which included peer-to-peer interaction and incorporating youth decision making (Sawyer et al., 2012). In addition, several youth-centered models, such as PYD and YPAR, have resulted in an impact on positive youth outcomes, such as improved interpersonal relationship, advocacy and leadership skills (Anyon et al., 2019), In response to current literature and my experience working with high school aged youth, I created YPEAM as a youth-centered mental health promotion program with a goal of increasing mental health literacy and reducing stigma.

Previous to this study, there was no mental health promotion program that centered youth decision making in the curriculum, and targeted primary barriers to mental health access. Overall, qualitative and quantitative results from this feasibility and acceptability study of YPEAM implementation, along with assessing desired outcomes (i.e., mental health literacy and stigma), demonstrated positive results. Study results were limited by small sample size and methodological limitations; however, the novelty of using PYD and YPAR offers promising results that may be incorporated into future interventions that focus on adolescent mental health promotion and prevention. Therefore, future mental health promotion programs may benefit from components of YPEAM, particularly when working with adolescents who are in a stage of life where investigators can capitalize on the developmental need of autonomy and decision-making.

Appendices

Appendix A. Figures and Tables

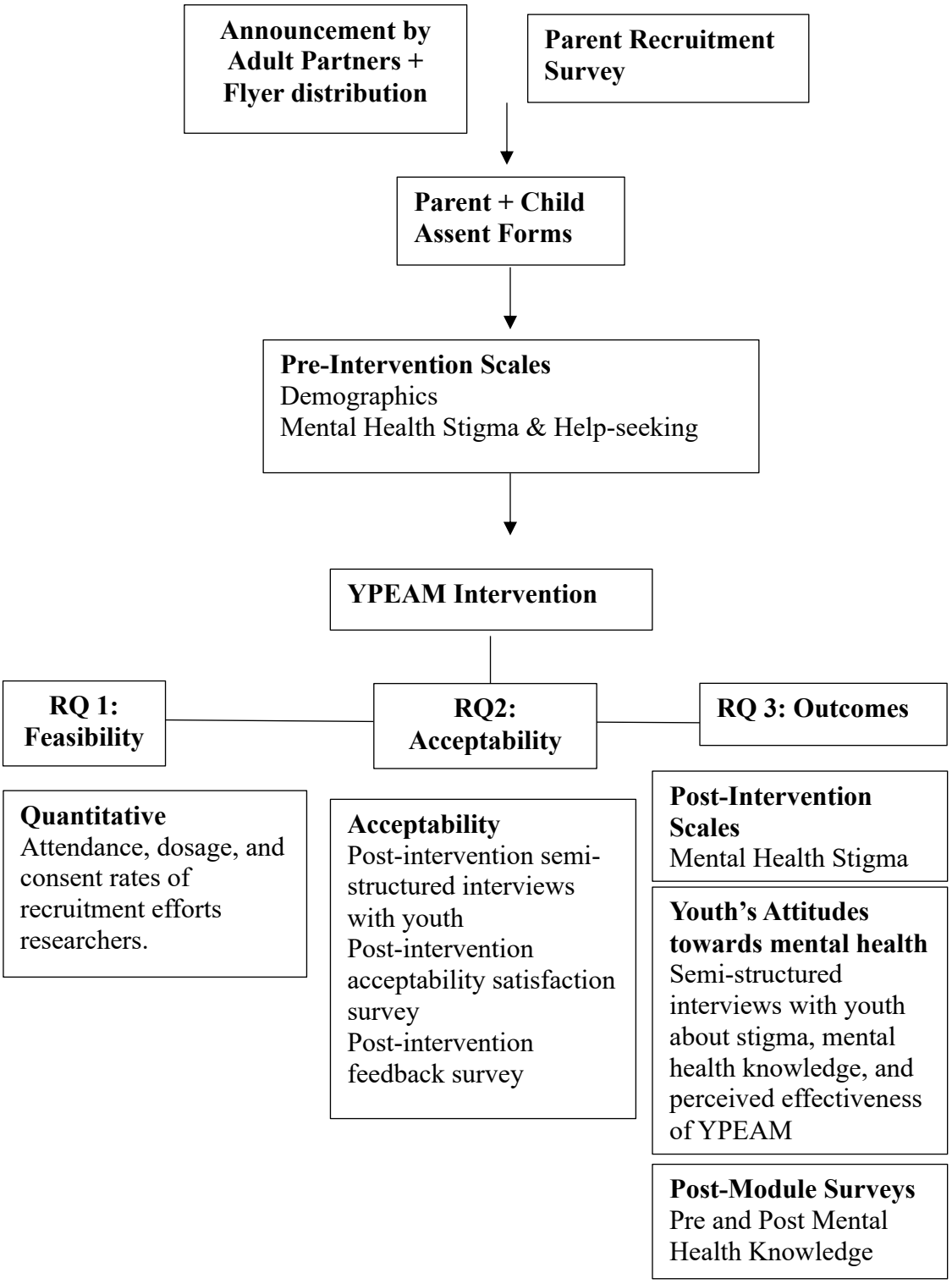


Table 6

Demographic Information and Prior Mental Health Treatment Disclosure

Participant	Ethnicity	Age	Gender	Prior Mental Health Treatment?
James	Hispanic/ Latinx	16	Male	Yes
Bobby	Hispanic/ Latinx	17	Male	Yes
Andres	Hispanic/ Latinx	15	Male	Yes
Juan	Hispanic/ Latinx	15	Male	No
Anthony	Hispanic/ Latinx	13	Male	No
Carlos	Hispanic/ Latinx	14	Male	No
Sam	White	16	Male	Yes
Yesenia	Hispanic/ Latinx & White	15	Female	No

Table 7

Pre and Post Module Mental Health Knowledge Survey Responses

	Module 1					
#	Q1: When youth and adults work together, do you think they share power? If yes, please explain. If no, please explain.		Q2: What do you know about mental health at this time?		Q3 How does our brain respond to stress?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
1	No		Bo		No	
2	I think not much but i feel like it does make sense like the adults being in power than the children since the kids are barely learning their life.	No, because we still have ways to learn than adults since they are wiser and know what to do.	I know that it is something of being affected on the inside but doesn't show on the outside like if i have stress i don't show it outside but always keep it inside.	It's important since it makes us know some patterns that we find unusual	Mostly panicking because I don't know how to deal with the situation.	Panics and decides to make decisions that are not very smart.
3	No I don't think so because adults naturally have this sense of authority as well as adults working in the government.	No, I don't think so because naturally, we are thought to repect adults or people older than us so then there is a certain kind of power	I know that it's important and that it affects the way we think, feel and makes decisions	I know that it is important and interesting	I know that there is good kinds of stress that can help motivation you to finish something like an assignment. But I would	Our brain deals with stress by working through it

		behind adults that youth see.			say generally negatively	
4	Yes I do I think they both can have power in decision making	Yes I think they both can, they can both share different perspectives	I know a bit but not very much	Trauma is different from ptsd	I think everyone responds differently to stress, but I respond by coping or sleeping	It responds differently like maybe it can cope with it
5	I think adults have more power	I think they typically when they work together the adult naturally takes control of the situation	Not very much	Mental health can impact the chemistry in your brain and impacts your daily life	It responds instinctivel y, the brain panics	It can respond to stress in three ways, fight flight or freeze
6	I think adults have a little more power then the kids because they're more wise	Yes because were equals	That it is an important part of a person	It is very important	It responds negatively	It responds negatively
7	No because adults would always put the youth first no matter what	I think they do because adults would always want the youth safe and have the same rights as them.	Not a lot if I'm being honest	Not much at the moment.	Our brain responds by being in a bad mood or having no energy to do things.	Our brain responds by wanting to become distant from others.
9	Did not join YPEAM until Module 4					

Module 2

#	Q1: What is stigma? If you have heard this term before, how have you heard it used before?		Q2: How do substances (e.g., alcohol, drugs) affect the brain?		Q3: What are some ways we can help our community feel more comfortable talking about mental health?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
1	E		Drugs affect the brain by controlling it and making the drugs the stuff you need		Drugs and suicide	
2	I haven't heard of it	I have learned it today and have notices that it was about how people make myths of other people for things like teens don't have mental health.	They mess up the brain that is growing in our teen years	They affect the area where our brain is growing and if we take these earlier at a younger age it is easier to get addicted.	I don't know	More activity
3	-a bad rep around a certain topic, person, place, belief	Stigma- is negative misinformation about a topic or a community	They can cause long term health problems	They alter the way you think and influence your habits	Normalizing it. Making it feel normal to talk about mental health and not see it as a weakness	Normalizing it
4	No	Yes	Alter your brain chemistry	Could change the	Share more facts about it	Speak more about it or make it

				brain chemistry		talked more about
5	A bad connotation around a subject	Negative connotation about a subject	It can alter the brain's natural function and specific parts of the brain	Effects its natural state of function and changes how different parts work	Less stigma around mental health	Have more communication about mental health
6	Nope	Stigma is a feeling that is bad and makes you not want to get mental help	They make it sleepy	They get the brain in a bad mood and feeling and it does things it usually wouldn't do	Taking nicely	By getting mental help and spreading awareness
7	I've heard about the word but I forgot what it meant	Stigma is a mark of disgrace or quality of a person.	Substances can be the answer to stress but can't help you mentally and physically.	It affects the the brain by the way the brain tries to receive any type of help.	This question confused me	We can put them in a group of people they feel comfortable with
9	Did not join YPEAM until Module 4					

Module 3

#	Q1: What are the most common mental health disorders for youth your age?		Q2: What are some common symptoms of these? Or any mental health conditions you know about?		Q3: How do you think culture influences mental health?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
1	ADHD anxiety		Suicide		No	

	depression suicide					
2	Stress, depression, and anxiety	Stress and depression	Isolation, hurting themselves, and always negative	Sad, not motivated, and having their heart race.	Like people being ashamed of themselves for their clothing and appearance	The way we grow up from different households like in a mexican household we need to be man not a man who is emotional but now seeing today lots of the culture is changing like being against people like the LGBTQ to now supporting them.
3	Depression		Anxiety, suicidal thoughts		Maybe in some cultures if there are more reasons to be depressed about	
4	Depression and anxiety	depression, adhd, anxiety	Being sad, not motivated	No motivation, not being able to pay attention to one single thing, being aware of	Negative and positive ways	The way you grow up or see mental health, experiences with parents

				everything or most things around you		
5	Anxiety and depression	Anxiety, depression, adhd	Isolation, sad	Overthinking, extreme sadness, etc	The way someone copes with mental illness	Culture can affect how someone copes and approaches the topic of mental health
6	Depression	Depression anxiety adhd	Suicide sadness breakups	Sadness lack of attention lack of confidence lack of hunger	I think it can influence ot to do good things	I think for some it influences it negatively
7	Depression	ADHD	Feeling down and wanting to end it all	Problem focusing on one thing	I don't really know how to answer this question	I don't know how to answer this question
9	Did not join YPEAM until Module 4					

Module 4

#	Q1: What are some common therapy approaches or techniques?		Q2: What do you think typically happens in a therapy session?		Q3: What are some reasons you think people don't go to therapy?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
1	Talking to other	Aba	Talking	Talking lady	Because they don't feel like it	They don't want to
2	Asking for help or doing the survey that the	Help with mental health issues or feel like they are	Talking about how the patient is doing	Talk about reflection on what's going on with their	Embarrassed to do it or thinking negatively.	Dont think they will get help.

	doctor gives us.	something that they self diagnosed themselves.	and maybe questions.	days they haven't met.		
3		A therapy session has a beginning, a middle and an end.		Therapists help their patients with coping mechanisms		Because they think that it doesn't work
4						
5	Waterboarding	I forgot	Talking about feelings	Helping the patients cope and methods to cope	Money, shy	Money problems, insurance, no resources, too scared
6	Asking about trauma	Keeping it calm	People get better	I think people break down	Because they don't think it's cool	Because they dont think its cool
7	Family Therapy	Asking family members	You get asked some personal questions.	You get asked personal questions.	They think it won't help them at all.	They think it's just a waste of time
9	Going to therapy or medication	Going to therapy and them listening to you	Talking about your problems and the therapist responds with suggestions	The therapist responds with suggestions and stuff	They're scared or think the don't need it	They're scared or feel they don't need it

Module 5

#	Q1: What are coping mechanisms?		Q2: What typically goes into a treatment plan for mental health?		Q3: If you wanted to, where would you get mental health support?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest

1	No data	Listen to music play music talk to friends go in the woods	No data	Treatment goals presenting concerns and paitenet’s history	No data	Counsels and crisis lines
2	I don't know	Being around friends and family.	Medicine	Being organized on what to do like saying that i need to take deep breaths.	From my therapists or doctor.	From my local clinic
3	No data	Coping mechanisms help people cope with their emotions and mental health issues	No data	Treatment goals and a written history	No data	From non profit organizatio ns
4	Things that can calm you down	Things someone can do to calm down emotions or actions	Goals maybe	Plans and goals to reach a certain point	Therapists	I already have support
5	No data	Ways to calm down symptoms	No data	Family history and treatment plan	No data	Counselor and local resources
6	Talking to people like therapists or using stress toys	Sitting in the rain alone	Idk	Names	No where i dont have any mental health problems	No where because I don’t need it
7	I forgot what they were.	Things that calm do you down	Talking to therapists	Talking with your	From people who have gotten	On mental health resources

				parents if you're a kid.	mental health support before	
9	Self harm, therapy, disassociation?	Self harm, working out, music, drawing, etc	Therapy and removal on sharp objects	Maybe a schedule	Therapy	A therapist

Module 6

#	Q1: How does your community help each other heal?		Q1: What is resilience?		Q3: What is post-traumatic growth?	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
1	No data	No data	No data	No data	No data	No data
2	No data	Have parties as a community	No data	Something that is able to be controlled	No data	Something that is out of control like goes above the line of resilience
3	No data	No data	No data	No data	No data	No data
4	No data	Watch movies, play board games or talk abo ur anything	No data	Bouncing back after a traumatic event	No data	Growing from a traumatic event
5	No data	Programs	No data	Bouncing back to where you were after a traumatic event	No data	Growing from a traumatic event past where you were before

6	No data	By listening to each others problems	No data	That's when you go down and come back up on the chart	No data	Passing your baseline.
7	No data	By surrounding themselves with food or throwing a party.	No data	Able to withstand or recover quickly from difficult conditions.	No data	That's when you go down and back up and beyond
9	No data	By hanging out and talking	No data	Coming back from your trauma just as strong as u were before	No data	Coming back from trauma stronger than u were before

Appendix B. Curriculum

Youth Participatory Engagement and Action in Mental Health (YPEAM)

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SUPPORT: BRITNEY WALTON, ISAAC BOUCHARD, JILL D. SHARKEY, PHD

Introduction

About the Curriculum

YPEAM is a novel, group-delivered, mental health promotion intervention designed to increase mental health literacy, decrease stigma, and provide a framework that allows for flexibility and adaptability that honors community needs. YPEAM is a curriculum-based intervention which includes the following six modules: a) understanding mental health, b) mental health stigma, c) social determinants of mental health (SDMH), d) Information on Specific Mental Illnesses, e) treatment modalities for specific mental illnesses, f) seeking help and finding support, and g) the importance of positive mental health. These modules are intended to be flexible and adaptable to the social context of each community as modified by community partners and youth participants. The development of YPEAM is informed by integrating and synthesizing literature on mental health accessibility, SDMH, barriers and facilitators of treatment, YPAR, and youth-focused interventions.

This curriculum is intended to be delivered and tailored for adolescents between the ages of 12 – 17 years old alongside adult facilitators. Nearly one in six youth, aged 6-17, meet diagnoses for a mental health disorder every year and 75% of lifetime mental illness begins before the age of 24 (National Alliance of Mental Health, 2021). Adolescence is often marked by the developmental stage where youth seek autonomy and decision-making power. The field can capitalize on the developmental needs for agency and decision-making power in a way that optimizes treatment engagement and adherence.

Theoretical Background

Positive Youth Development (PYD) is an umbrella term that incorporates concepts from various disciplines and concepts. Researchers have also attempted to distinguish PYD through four features: 1) ecological contexts (e.g., neighborhoods, schools, programs), 2) producing experiences and supports, 3) experiences that promote positive developmental outcomes, and 4) utilizing promotion methods to increase youth access to positive experiences, resources, and opportunities.[1] PYD has been used in fields such as psychology, education, anthropology, public health, and public policy. The wide-spread utilization of PYD has proven to be successful in developing policy solutions and system changes that promote youth development. Ultimately, PYD aims to promote one or some of the following: bonding, resilience, social competence, emotional competence, self-efficacy, positive identity, and opportunities for prosocial involvement.[1] Unsurprisingly, PYD is also considered a core component of YPAR. Due to YPAR's focus on PYD where youth's strengths and agency are centered, YPAR and PYD can serve as an intentional step to counter frequent adult-generated, problem-centered narrative that is often associated with youth.[2] In line with PYD, YPEAM was created as a way to encourage the following: 1) promote youth assets such as incorporating their lived experiences, social context, and strengths into their learning within the curriculum, 2) encourage youth agency by contribution to the curriculum, gaining knowledge about mental health treatment plans, and encouraging youth to develop solutions to improve mental health systems and 3) co-create enabling environments by encouraging peer bonding, youth-

responsive services, promoting youth-centered approaches to health. The overarching goal of YPEAM is to enhance mental health knowledge, reduce stigma, and increase youth engagement through PYD frameworks and promotion methods.

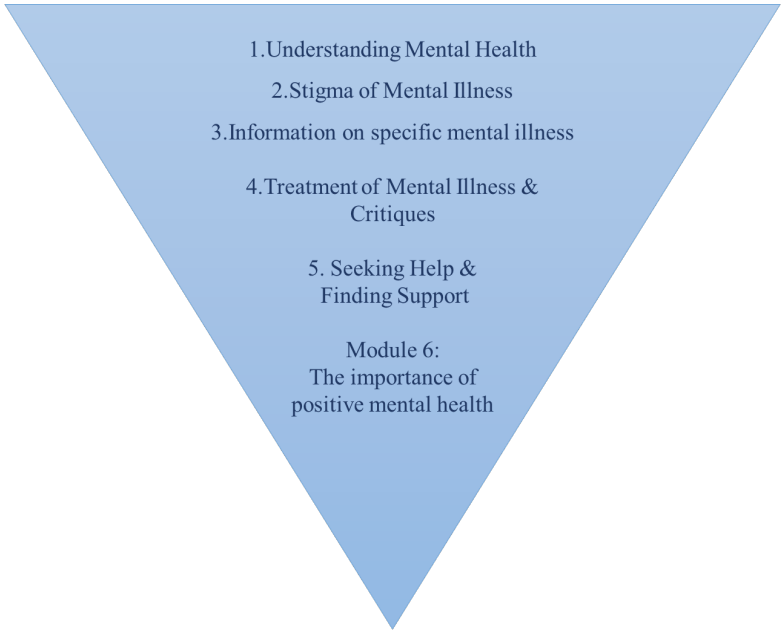
Modules

The purpose of the modules is to provide structured and readily accessible lesson plans for mental health professionals, school staff, teachers, community organization staff, or lay community health workers. It is intended to be flexible to community needs which is reflected in the participatory components. Each module incorporates "core" lessons but also includes activities that can be modified, changed, or adapted. Core activities within modules will be clearly denoted within the curriculum. Participatory components/activities are outlined in the table below but can be modified as facilitators and participating youth see fit. Each module is intended to take up to two sessions.

The rationale for the construction of the modules was motivated with the intention of building from broad information to the most specific information (i.e., mental health resources within their community). The curriculum is organized in a way that each module builds upon the last.

Participatory Component and Modules

The participatory component of this curriculum is modeled after Rodriguez and Brown's[3] conceptualization of youth participation within research and has been adapted to be flexible for a curriculum. First, YPAR is inquiry-based; curriculum modifications and changes are grounded in youths' lived experiences and center them as experts. Second, it is participatory; youth are centered as decision makers in selecting which modules to change from the participatory components. Lastly, YPAR is transformative; the purpose of YPAR is to share a framework with youth in order to challenge knowledge creation and practices within mental health systems in order to be more reflective of their needs.



In the table below, the participatory components are outlined with a brief description of how these modules are intended to be reflective of community needs and context. These modules are also optional. Students enrolled in this program will receive an outline of the curriculum before it starts, during week one, and provide facilitators with feedback on if the participatory modules are something they think they

can benefit from or want to learn about. Students are encouraged to provide other suggestions to replace the suggested participatory modules. Additionally, students will always have the option to change the course of the curriculum as they see fit. For example, if students think it is important to spend more time in module 3, facilitators should adjust the curriculum to meet their requests and needs.

Format of the Modules

Each module includes several key components:

- The **overview** provides a summary of the module.
- The **learning objectives** outlines specific aims students should learn from completing the modules.
- The **major concepts** outline the central ideas that the module is designed to address.
- The **lesson plans** provide details about how to execute activities as a reflection of the major concepts and learning objectives.
- The **required materials** section provides details about the resources needed to complete the activities within each lesson plan and module.
- The **in advance** section provides instruction on needed materials that we suggest preparing before facilitators implement the lesson plans.
- The **participatory questionnaire** is a survey, facilitators provide youth after each lesson plan to ensure youth participation.

Overview of the Curriculum

Module	Major Concepts	Participatory Modules
Module 1: Understanding Mental Health	● Everyone experiences mental health, regardless of mental health diagnoses or illness. ● Understanding what mental health is and various contributors to its development. ● Humans experience a stress response	Activity 3: What is trauma: What is trauma and how does trauma impact their community? Activity 4: Mental Illness in the media: How is mental illness portrayed in the media they use (e.g., movies, on social media).

Module 2: Stigma of Mental Illness	● Mental health development, treatment, and treatment access is influenced by complex biological and socio environmental factors. ● Stigma can often act as a barrier for communities and individuals who need treatment. ● Understanding stigma, mental health, stereotypes, and misconceptions can help demystify and dispel mental health stigma. ● Stigma is not only related to mental health.	Activity 2: Substance Use and Mental Health: How can mental health and substance misuse co-occur? Conversations about substance use prevalence. Activity 3: Community perceptions about mental illness + Substance use: Exploring how stigma is expressed within their community context.
Module 3: Information on specific mental Illness	● Mental illness presentation can vary depending on a person's biology, environment, and access to resources. ● There are mental illnesses that are more common than others. ● Mental health symptoms can co-occur with other mental health symptoms. ● Mental illnesses can be treatable.	Activity 3: Cultural considerations of mental health presentations: Open discussion about how mental health symptoms can present in different ways and may not be pathologized in some cultures.
Module 4: Therapy approaches, process, and critiques	● Overview of the most common treatment modalities (e.g., cognitive-behavioral therapy, acceptance, and commitment therapy). ● Understanding the typical format of therapy. ● Social, cultural, economic, and environmental factors influence the	Activity 2: What do I do in therapy: Demystifying the process and common format of therapy.

	development of mental health challenges and influence an individual's access, quality, and perception of mental health services.	
Module 5: Seeking Help & Finding Support	● Treatment plans can vary depending on treatment modality, severity, and patient needs. ● Understanding treatment plans. ● Exploring local community resources and building a mental health resource bank.	Activity 3: Building a local resource bank: Youth will collaborate to build a list of local resources.
Module 6: The Importance of Positive Mental Health + Community healing	● Community-specific and youth contextualized ways of healing. ● Communities have their own forms of healing and coping mechanisms that may not be recognized by the field of psychology. ● Understanding resilience and post-traumatic growth.	Activity 1: What does healing look like in your context? (Community healing): Discussion on various forms of healing and what psychology considers healing.

Overview of the Activities

Module	Activities	Duration
1	Intro: Rapport Building Activities Activity 1: Mental Health and Mental Illness Activity 2: What is trauma?	30 minutes 40 minutes 40 minutes

2	Activity 1: Defining stigma Activity 2: Substance Use and Mental Health Activity 3: Community perceptions about Mental Health, Mental Illness, and Substance use Activity 4: Reducing Stigma	25 minutes 45 minutes 40 minutes 20 minutes
3	Activity 1: Common mental health symptoms and mental illness in adolescents Activity 2: Mental health and mental illness in media Activity 3: Cultural considerations of mental health symptom presentation	45 - 60 minutes 20 minutes 40 minutes
4	Activity 1: Learning about common treatment modalities Activity 2: What do I do in therapy? Activity 3: Barriers and Facilitators to people accessing mental health (social determinants of mental health) & how we can help	45 minutes 40 minutes 40 minutes
5	Activity 1: Coping Mechanisms Activity 2: Building a treatment plan Activity 3: Building a local resource list Activity 4: How to access local resources	 30 minutes 30 minutes 30 minutes
6	Activity 1: What does healing look like in your context? (Community healing) Activity 2: Understanding resilience and post-traumatic growth + reviewing coping	30 minutes 30 minutes

	mechanisms Activity 3: Celebration – should take up the whole last session	60 minutes

Orienting Youth to Curriculum and Participatory Component

Overview

Participatory Action Research (PAR) is intentional about challenging traditional notions of knowledge among researchers and community partners and disrupts the "expert" role of researchers. PAR is a process that seeks to share knowledge with community members about social inequities and also works alongside community to creates avenues for change that are sustainable.[4] PAR presents a strong base as a collaborative framework for developing mental health interventions that align with community needs and does not place the researchers as the expert.

This curriculum aims to align with frameworks of Youth Participatory Action Research (YPAR) in order to disseminate mental health knowledge to youth in a way that is reflective of their unique community needs. Rodriguez and Brown[3] conceptualized YPAR into three key principles. First, YPAR is inquiry-based, meaning that research and implementation situate youth as the experts. Second, it is participatory, and youth are key decision makers in various phases of the project. Third, the YPAR framework is transformative and meant to challenge practices within current systems youth experience on a daily basis. As a research framework, YPAR has continuously demonstrated a strong approach to collaborate with and engage community members, develop avenues for change, and adhere to community needs. Therefore, it is likely that as the field of psychology innovates new frameworks of healing for communities who have historically been excluded from psychological research, YPAR can provide a collaborative framework to co-create and implement novel interventions.

Purpose

- Orient youth participants to the participatory component of the curriculum
- Challenge hierarchies between adult facilitators and youth participants
- Provide an overview to youth participants about how they can change and modify the curriculum

Materials

- Handout: Adult-Driven to Youth-Driven spectrum
- YPEAM participatory component PowerPoint

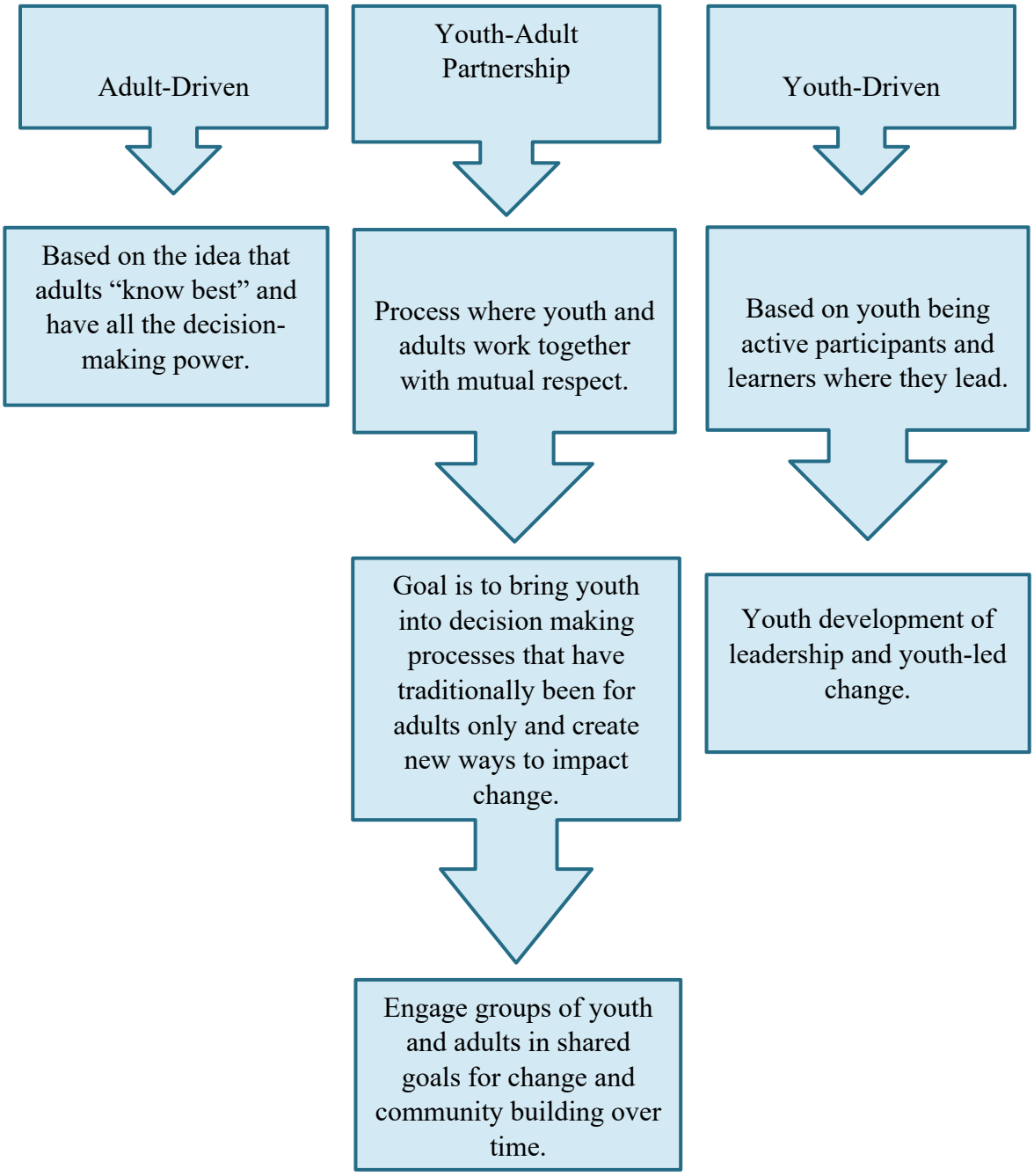
How-to (30 minutes)

- Review the Adult-Driven to Youth-Driven spectrum handouts with youth and explain that historically, decision-making is led by adults.
- Emphasize how this curriculum will be participatory in nature when thinking about lesson plans and group discussion and learning.
- Ask students to share what they know and want to learn about mental health. Write these on a flipchart/whiteboard. Let students know that we will return to this during the end of this lesson.
- Use YPEAM participatory component PowerPoint that outlines the following steps in more depth:

- Adult facilitators will do a brief overview of the curriculum and point out the ***potential*** sessions within the curriculum.
- Present ***potential*** lessons as their opportunity to modify, change, remove, and replace.
    - At the beginning of every module, youth will have the opportunity to share the following:
        1. If they want to maintain the current lesson plan or remove and replace it with something else.
        2. If they decide to maintain the potential lesson plan, they will have the opportunity to share what they want to learn about that specific lesson and the facilitator can adjust accordingly.
        3. Any reflections on the other lesson plans within the module.

Handout: Adult-Driven to Youth-Driven spectrum

(Adapted from Institute for Community Research, 2014)



Module 1: Preparation

Understanding Mental Health

Overview

Given the rise in social media use among adolescents and readily accessible mental health content, adolescents are even more aware and familiar with mental health. Although, deeply understanding how mental health disorders are developed and what factors contribute to mental health and illness is less known. Limited knowledge on mental health creates a barrier for accessing and understanding mental health services, and in turn, contributes to unmet mental health needs. Radez et al.[5] reported that in 35% of the studies exploring mental health barriers and facilitators, youth reported barriers about being uncertain if their problems required and could benefit from treatment. Increasing mental health literacy and providing extensive psychoeducation of mental health presentations and some treatment modalities may also help demystify the knowledge, access, and process related to mental health treatment.

Learning Objectives

In this module, youth will learn:

- To explore the contributing factors to the development of mental illness.
- That mental health and mental illness can vary widely and can be context dependent.
- Basic language around mental health.
- Basic benefits and potential critiques of seeking treatment.

Major Concepts Addressed

- Everyone experiences mental health, regardless of mental health diagnoses or illness.
- Understanding what mental health is and various contributors to its development.
- Humans experience a stress response which is necessary and normal.

Participatory Component

The participatory lesson plan for this module is *what is trauma* and *mental health in the media.* Participatory components are meant to be interpreted as ***potential*** activities. This means that after youth have seen the activities and participatory components to the module, they can choose to keep the potential modules highlighted in blue OR they can choose to suggest another topic they may need more information on. This may be due to better fit within their community context or current circumstances.

Activities

- Rapport Building Activities (30 minutes)
- Activity One: Mental Health and Mental Illness (40 minutes)
- Activity two: What is trauma? (40 minutes)

Module 1: Pre-activity orientation for students

Group Rapport

Overview

The goal of this sections is to begin group rapport and safe space. Although rapport is built across the modules, it is important to build a general understanding of the group. The following activities are intended to build group trust and affiliation. Below there are several suggestions to begin building a co-created safe space among facilitators, youth participants, and others. Any other activities that encourage and facilitate group rapport are also encouraged. The below activities are only potential examples of what the facilitator chooses to implement within their group and community setting.

Creating Group Guidelines/Norms for Engagement: Setting group guidelines for engagement allow youth to feel comfortable sharing thoughts, beliefs, and their experiences. This serves as an important first step to establish a safe space. The facilitator is encouraged to start with a few examples of group guidelines. Some examples may include:

- If others are speaking, don't speak over them
- Be open to varying opinions
- Share from your own perspective by using "I" statements
- [Have students fill in the remainder]

Identity Maps (30 minutes)

- Distribute paper and colored markers.
- Each student creates a "map" of important identities or "parts" of them. Demonstrate your own identity map (as a facilitator) as an example.
- Give students 15 minutes to create their own map.
- The remaining 15 minutes all members of the group (including youth and the facilitator) will share their identity map with the rest of the group.

Module 1 Activity 1: Mental Health & Mental Illness

Purpose:

- To introduce students to basic functions of the brain and how it controls our cognition, perception, emotions, signaling, and behaviors.
- Provide an understanding that mental health and mental illness are different and can co-occur.
- Introduce how our brains work and how it influences behavior.

Approximate time: 40 minutes

How-to:

- Place flipcharts in four areas of the room to represent the five areas from above (cognition, perception, emotions, signaling, behavior).
- Engage students in a conversation. What does the brain control? What does it influence?
- Give a brief overview of how each one of the five areas are controlled by the brain.
    - Cognition: The mental processes associated with thinking, learning, planning, memory. For example, controlling response to fear.
    - Perception: the mental process of becoming aware of or recognizing sensory information (taste, visual,
    - Emotions: Emotions happen after we become aware of happy or painful experiences.
    - Signaling: An electrical impulse triggers the release of a chemical messenger to communicate information. This means that impulses and messages spread across the brain.
    - Behaviors: The ways in which a person acts or conducts oneself.
- Gallery Scenario (use document below)
    - Have **five** students volunteer for a writing task. Assign each student a role/large stick not around the room (i.e., cognition, perception, emotions, signaling, and behaviors). Read the definitions from above and have each student write the definition at the top of the flipchart.
    - Tell the students you will be reading them a scenario and want them to identify which basic function they think it aligns with the best.
- Discuss with the youth. What did they learn? How might disruptions in these areas affect our mental health and mental illness or symptoms of mental illness?
    - Explain to students that these functions occur a lot quicker than explained in the scenario and are happening all the time, but the scenario is in place to provide an illustration.
    - Also explain to students that problems in signaling for example, may lead to the development of mental illness.

- Can use the game telephone to illustrate the circuits and "talking" of signals. If the signaling doesn't work, the message doesn’t get communicated.

Gallery Scenario

Primary Scenario: You are playing soccer with a group of friends at a local park.

- Cognition: Juan yelled at Lupita: “Lupita, I remember this cool trick you did the last time that we played together. Can you show me how you did that?
    - This incorporates planning and memory.
- Perception: Lupita heard Juan from across the field and responded, “Oh, I can definitely show you the coolest trick but I’m unsure if you’ll be able to match it!”
- Signaling: Messages are received, and impulses are sent to various parts of the brain that make Juan feel nervous, get ready for planning efforts, and execution of the task.
- Emotion: Juan became aware of the challenge and felt nervous about being able to replicate Lupita’s trick as well as she engaged in it.
- Behaviors: Juan tries the trick and succeeds! Yay!

Additional Video for City metaphor:

How Depression Affects The Brain - Yale Medicine Explains

https://youtu.be/BZOLxSQwER8

Module 1 Activity 2: What is Trauma?

Purpose:

- To introduce youth participants to the stress response system of the brain and how it relates to mental health.

Approximate time: 40 minutes

Materials

- Clear Bucket/ bowl
- Red balls (ping-pong, yarn, cotton balls)

How to:

- Draw an image of the brain on the white board/ flip charts.
- Ask students what some potential scenarios that elicit a fear response.
    - Provide some prompting examples, such as seeing a bear on a hike, a dog barking at you unexpectedly, or car crash.
    - Follow the student's lead in creating a scenario with their examples.
- Use their scenarios to build guide students through the different parts of the brain when reacting to a fear response (i.e., prefrontal cortex, amygdala, hippocampus, hypothalamus).
        - Prefrontal cortex: Inhibits the amygdala when presented with stimuli so that it is not overreactive.
        - Amygdala: triggers and initiates flight or fight response but will also store that for future purposes. Can be overreactive to stimuli as a result of the prefrontal cortex not inhibiting.
        - Hippocampus: Memory process, storage, mood, and stress regulation
        - Hypothalamus: Core processes that keep us alive (e.g., if we are too hot, it will send a signal to cool us down), releases hormones, in order to maintain homeostasis.
- Discuss with students the purpose of fear responses and the evolutionary benefit.
    - Quick responses gave us the ability to react quickly to keep us safe.
    - Prompt students with questions: What happens when people have experience chronic stress and fear?
    - Illustrate re-occurring trauma with a bucket/clear bowl and red balls.
        - Our brains get used to functioning on "alert" which elicits the fear response + the associated coping skills so often that it leaves little room to regulate.
        - This is known as complex or re-occurring trauma.
        - There are ways to help this that we will be talking about later in the curriculum.
- End lesson by guiding youth through a grounding activity and letting students know that we will be learning more about coping mechanisms later in the curriculum.
-

Module 2 Preparation

Stigma of Mental Illness

Overview

Stigma around mental illness can have negative effects on the help-seeking behaviors of youth who need mental health support. There are various forms of stigma, such as, public, self, label avoidance, structural, courtesy, automatic, and multiple stigma.[6] Public, self, structural, and multiple stigma are particularly relevant to the issue of mental health access and treatment.

- Public stigma is when there is a public endorsement of prejudice and discrimination towards a minoritized group (i.e., people with mental illness are violent).
- Self-stigma refers to when individuals that experience mental health concerns are aware, agree, apply, and internalize public stereotypes into their self-concept.[7,8]
- Structural stigma occurs when policies restrict opportunities for people from minoritized identities.[9]

Specifically for youth, who are at a developmental age of developing close peer relationships, stigma may be a key point of intervention to support youth in their openness to seek treatment. A systematic review of 53 studies that explored reasons why youth do not access or seek mental health support revealed that perceived public/social stigma was the second most common (92%) theme among youth respondents behind limited mental health knowledge.[5]

These findings suggest that addressing stigma and providing intensive mental health psychoeducation may be a key point of intervention for young people. Notably, Eylem et al.[10] found that the consequences of social stigma, in relation to mental health treatment, is experienced more for those from minoritized communities, acknowledging that stigmatization is compounded when individuals identify as a part of multiple minoritized groups.

Learning Objectives

In this module, student will learn:

- To understand the various types of stigma that impact mental health and illness and its impact on seeking support.
- To explore perceptions of mental health and help seeking behaviors in their own communities.
- To understand why stigma is specifically important to target for youth.
- Explore ways to address stigma within their social and community context.

Major Concepts

- Mental health development, treatment, and treatment access is influenced by complex biological and socioenvironmental factors.
- Stigma can often act as a barrier for communities and individuals who need treatment.
- Understanding stigma, mental health, stereotypes, and misconceptions can help demystify and dispel mental health stigma. Stigma is not only related to mental health.

Activities

- Activity 1: Defining stigma (25 minutes)
- Activity 2: Substance Use and Mental Health (45 minutes)

- Activity 3: Community perceptions about Mental Health, Mental Illness, and Substance use (40 minutes)
- Activity 4: Reducing Stigma (20 minutes)

Required Materials

- Large Flip Charts
- Sticky notes and other paper materials
- Yarn for activity 3 and 4
- TEDxYouth - Kevin Breel: Confessions of a Depressed Comic:
    - www.youtube.com/watch?v=VYs05qPycYQ

In Advance

- Gather materials as mentioned above

Participatory Component

The participatory components for module 2 are activity 2: *Substance use and mental health* and activity 3: *Community perceptions about mental illness + substance use.* These activities are intended to be potential lesson plans for this module but are flexible to youth participants' suggested changes.

- Before beginning activity 1 – show students the layout of module two. Remind students that they are able to change the curriculum and suggest new areas of interest.

Module 2 Activity 1: Defining Stigma

Purpose

- To provide a general overview of what stigma is and the various forms of stigma.
- To explore the relationship between mental health and seeking support, and the treatment and attitudes towards people who have a mental illness.

Approximate time: 25 minutes

Materials

- Flip Chart Sticky Notes
- Markers

How-to

- Place three large flipchart sticky notes across the room.
- Ask students what "stigma" means? What contexts have they heard it in?
- Ask three students to volunteer as today's note taker. Each student will be stationed at one of the three sticky notes.
- Provide the definitions of each type of stigma to them to be able to write down on their flipchart. See definitions in the overview section.
- Pass out sticky notes to students. Have each student write down something they've heard about mental health, mental illness, and people with mental illness and place the sticky on the appropriate flipchart.
    - Example: People with mental illness are lazy. This would be placed under the public stigma flipchart.
- Have students engage in a gallery walk by walking around the room and read the sticky notes on each flipchart.
    - Note: It is likely that one type of stigma may have more examples. This is okay. It will provide for fruitful discussion later and as the facilitator, you can provide examples after the gallery walk.
- Lastly, engage students in a discussion by using the guiding questions below.

Guiding Questions:

- Why do you think there is stigma around mental illness?
- How have other health conditions or social issues been stigmatized throughout history? (Potential answers: AIDS, LGBTQ+ communities, divorce)
- How do you think stigma affects people's lives?

Module 2 Activity 2: Substance Use and Mental Health

Purpose

- To explore how mental health and substance use relate and interact with each other.
- To understand the basis of addiction.
- To explore how substance use and mental health are both stigmatized.

Approximate time: 45 minutes

How-To

- Place two flipchart sticky notes around the room. Label one the limbic system, and the other the pre-frontal cortex.
- Use sticky notes (of a single color) to have students place the basic functions of the limbic system and the frontal cortex on each large flipchart.
  - Limbic system basic functions: Responsible for basic survival instincts. When you do essential things to stay alive like eat, sleep, drink water, and build relationships, the brain reinforces this behavior by releasing dopamine which is a reward! This is then recorded in our memory and then we seek it again by doing the same things.
  - Pre-frontal cortex: This region is where decision and impulse control exist.
- Next explain that when drugs and alcohol are used it activates the same response in the survival center. When use is repeated, the substance can hijack that part of the brain and weakens that prefrontal cortex which may make the brain think that its primary need to survive is the substance.
  - This also means that food, relationships, and shelter may not be at the same priority as before.
- Lastly, have students use a different color sticky note to cover up the basic survival skills that may be impacted by continued use.
- Note: Share with students that substance use, and misuse are more complex. There are certain risk factors that lead some people to use substances more frequently than others.
  - For example: Risk factors include genes, age of exposure, and drug availability matter. Protective factors include caregiver involvement, limiting availability, and increasing community attachment + relationships.

Materials

- Resource for facilitator: Mental Health Disorders and Teen Substance Use
  - Video on brain function & the brain: https://youtu.be/s0bqT_hxMwI
- Flipchart
- Markers

Module 2 Activity 3: Community Perceptions about Mental Health, Mental Illness, and Substance Use

Purpose

- To provide a space for students to discuss community perceptions related to mental health, mental illness, and substance use.

Approximate time: 40 minutes

How-To:

- This activity will be largely discussion based.
- Introduce the activity: Similar to what we talked about at the start of this module, defining stigma, today we're going to talk about what you've heard in your community about mental health, mental illness, and substance use.
- After introducing the activity, the facilitator can begin with the guiding questions below.

Guiding Questions

- What are some things you've heard about related to substance use in your community?
- What conversations have others in your community had when talking about mental health and substance use at the same time?
  - Do people talk about them as one leading to the other? Impacting the other?
- How do you think access to substances affects *your* community?
- What are some things we can do to change perceptions of mental health, mental illness, and substance use within this community?
  - **Note: Write these down because they will be used next activity!**

Materials

- None needed.

Module 2 Activity 4: Reducing Stigma

Purpose

- To explore ideas of what reduces stigma around mental illness.

Approximate time: 20 minutes

How-To

- Remind students of their ideas for reducing stigma from their last activity.
- Place three large flipchart sticky notes around the room. Label them as school, home, and community.
- Encourage students to think about various solutions in the areas of school, home, and community.
- After students have drafted their own ideas of what can reduce stigma in these various areas, have all students stand up and situate everyone (including the facilitator/s) in a circle.
- Have each student share something random about themselves (e.g., favorite color, food, what they did for fun yesterday). The facilitator begins.
- As each person shares something, pass the yarn to someone else and have them share. Continue this until everyone in the group has shared.
- At the end, share with the students that this illustrates two of the most effective ways to reduce stigma.
    - Sharing stories/information with each other. This helps us get to know each other. If we share about mental illness, people are less likely to believe/create negative stereotypes.
    - Creating community and demonstrating that we are all connected regardless of substance use, mental health, or mental illness.

Materials

- Flipchart sticky notes
- Markers
- Ball of yarn

Module 3 Preparation

Information on Specific Mental Illness

Overview

In this module, students will learn about the most common symptoms and mental health disorders that affect youth between the ages of 3 – 17 years old.

Note: The statistics presented in this presentation are the most recent data obtained from the Center for Disease Control/ Prevention (CDC) and should be updated accordingly for implementation of the curriculum.

Learning Objectives

In this module students will learn to:

- Recognize common symptom presentation of depression, anxiety, and attention deficit-hyperactivity disorder (ADHD).
- Gain a better understanding of how the symptoms can present in various settings (school, home, work).

Major Concepts

- Mental illness presentation can vary depending on a person's biology, environment, and access to resources.
- There are mental illnesses that are more common than others.
- Mental health symptoms can co-occur with other mental health symptoms.

Activities

- Activity 1: Common mental health symptoms and mental illness in adolescents (45 - 60 minutes)
- Activity 2: Mental health and mental illness in media (20 minutes)
- Activity 3: Cultural considerations of mental health symptom presentation (40 minutes)

Participatory Component

The participatory component for module 2 is *Activity 3: Cultural considerations of mental health symptom presentation.* These activities are intended to be potential lesson plans for this module but are flexible to youth participants' suggested changes.

- Before beginning activity 1 – show students the layout of module 3. Remind students that they are able to change, modify, or replace.
  - Also ask students what they would want to learn from this module so that the facilitator can adapt as necessary

Module 3 Activity 1: Common Mental Health Symptoms and Mental Illness in Adolescents

Purpose

- To distinguish between symptoms of a mental illness and a diagnoses of a mental health disorder.
- To introduce students to a basic understanding of the symptoms associated with the most common mental health disorders in youth: ADHD, depression, and anxiety.

Approximate time: 45 – 60 minutes

How-To

- Place three flipchart sticky notes around the room. Label them with ADHD, depression, and anxiety.
- Ask three students to volunteer to record responses from the rest of the group. Give each student a black marker so that all answers from the group are recorded in ONE color.
- Ask students what they have heard in relation to each of these.
  - This can be anything with the intention of it leading to discussion and presentation of common symptoms.
- After each group shares their responses, relation to each of these mental health conditions, give each student a different marker (any other color than black).
- The facilitator will read out the symptoms for each as the student records. Refer to the link CDC page for symptoms related to each mental health disorder:
  - Depression: https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx
  - Anxiety: https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx
  - ADHD: https://www.mayoclinic.org/diseases-conditions/adhd/symptoms-causes/syc-20350889
- Highlight that many of these symptoms may overlap with each other and that people often have co-occurring mental health diagnoses.
- At the end of the discussion, ask students the following question and facilitate a conversation:
  - If someone is sad, does that mean that they have depression? (Answer: not necessarily)
  - If someone is feeling nervous, does that mean that someone has anxiety? (Answer: not necessarily)
  - The purpose of this discussion is to explain to students that symptoms can be present without a necessity for a diagnosis. It is normal to be sad and worried.
- Remind students that mental health professionals have a specific criteria to decide when and how symptoms can lead to a diagnosis.

Materials: 3 black markers, Additional colorful markers, Flip charts

Module 3 Activity 2: Mental Health and Mental Illness in Media

Purpose

- To encourage students to critically think about consumption of media and how that can positively influence or mislead audiences about topics related to mental health and mental illness.

Approximate time: 20 minutes

How-To

- Note: By "media" this curriculum hopes to engage youth in conversations about social media and other media (e.g., movies, TV shows, YouTube, documentaries).
- Task students to bring up a piece of "media" that they can think of that has something to do with mental health. Remind them that this can be any media.
- Ask students where they usually hear about mental health.
- Ask students to discuss and critically evaluate how mental health and/or mental illness is being discussed. Were there any examples of stigma? How did this affect the main character (if a film-based media)?
- Ask students how they believe media contributes to mental health awareness, mental illness, and mental health?

Materials

- None

Module 3 Activity 3: Cultural Considerations of Mental Health Symptom Presentation

Purpose

- To explore cultural considerations of how mental health symptoms can present.
- To explore how culture influences ways of healing.

Approximate time: 40 minutes

How-To

- Begin by asking students what "culture" means? On a white board/flip chart note write down some of the key phrases students share. If there is something that is repeated, place a tally mark next to it.
- Share the following definition with students: Culture is an umbrella term which encompasses the social behavior, institutions, and norms found in human societies, as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in these groups.
- Emphasize that culture is a *shared* experience. Shared knowledge and ways of being.
- Transition students to thinking about culture and mental health.
- **Use the guiding questions below to facilitate a conversation with students:**
    - How does culture influence how you think about mental health?
    - What is your experience in how your family and community copes/heals?
        - If students struggle with an example, provide one from your own life (e.g., gathering to have coffee and pan dulce with family – not explicitly "therapeutic" but provides connection and opportunities to share)
    - In your community, is it more likely to talk about troubles/concerns/feelings with someone in your family/community or someone outside of it?
    - How do you think cultural norms, practices, and expectations affect someone when they do want to seek support outside of their community?
    - What might be some strengths from being connected to your culture and community?

Materials

- White board markers
- Regular markers
- Flip chart or white board

Module 4 Preparation

Therapy Approaches, Process, & Critiques

Overview

Adolescence is often marked by the developmental stage where youth seek autonomy and decision-making power. Yet, youth are often not well-equipped to be active participants in their treatment planning. Treatment modalities and knowledge of treatment components (e.g., behavioral activation, therapeutic alliance) are typically accessible to clinicians only. This module aims to demystify mental treatment and processes and also seeks to provide information to youth so that they are better able to be active participants in their mental health treatment if they decide to seek treatment.

SAMHSA developed an evidenced-based resource guide that is meant to improve health outcomes for youth at risk for, experiencing, or recovering from mental and/or substance use disorders.[11] This treatment guide is intended to support clinicians with treatment selection and application for youth. The guide highlighted three main treatment modalities for co-occurring for serious emotional disturbances (SED), serious mental illnesses (SMI), and substance use disorders (SUD) and their effectiveness with youth. In their review of various peer-reviewed studies evaluating the effectiveness of Cognitive Behavioral Therapy (CBT), it has resulted in reduced substance use and improved depressive symptoms.[11] Multidimensional family therapy (MDFT) was also highlighted as a treatment that reduced problems associated with substance use and internalized mental health symptoms (e.g., anxiety). However, these treatments have primarily been studied with western, educated, industrialized, rich, and democratic (WEIRD) adults and therefore, may have limited generalizability to those not from WEIRD backgrounds.[12]

Learning Objectives

In this module students will learn to:

- Describe common treatment modalities used for adolescents.
- Understand the basic format of therapy.
- Explore barriers and facilitators to accessible mental health services.

Major Concepts

- Overview of the most common therapy approaches (behavioral, cognitive, humanistic, etc.)
- Understanding the typical format of therapy.
- Social, cultural, economic, and environmental factors influence the development of mental health challenges and influence an individual's access, quality, and perception of mental health services.

Activities

- Activity 1: Learning about common treatment modalities (45 minutes)
- Activity 2 What do I do in therapy? (20 minutes)

- Activity 3: Barriers and Facilitators to people accessing mental health (social determinants of mental health) & how we can help (30 minutes)

Participatory Component

The participatory components for module 4 are activities 2: *What do I do in therapy and* 3: *Barriers and Facilitators to people accessing mental health.* These activities are intended to be potential lesson plans for this module but are flexible to youth participants' suggested changes.

- **Before beginning activity 1** – show students the layout of module 4. Remind students that they are able to change, modify, or replace.
  - Also ask students what they would want to learn from this module so that the facilitator can adapt as necessary

Module 4 Activity 1: Learning about Common Treatment Modalities

Purpose

- To provide a base of knowledge of therapy approaches.
- To critically think about which, if any, of these approaches may be helpful for them or others they know.

Approximate time: 40 minutes

How-To

- Prior to beginning, place five flipchart sticky notes around the room. Label them: psychodynamic, behavioral, cognitive, humanistic, and integrative/holistic.
- Ask five students to volunteer as scribes/note-takers. Provide definitions for each while highlighting important components of each approach.
- Psychodynamic: Psychodynamic focuses on changing behaviors, feelings, and thoughts by exploring unconscious meaning and motivation often beginning in childhood.
  - Key components: unconscious meaning and motivation
- Behavioral: Behavioral approaches are focused on learning's role in developing behaviors.
  - Key components: associative learning (e.g., learning that a stimulus like a sound is associated with an outcome)
- Cognitive: This approach focuses on what people think and how it affects their emotions and what they do.
  - Here the facilitator can mention one of the most common treatment modalities (i.e., cognitive behavioral therapy) that combines both behavioral and cognitive approaches that focuses on how thoughts, feelings, and behaviors are interrelated and can affect the outcome of the other.
- Humanistic: Humanistic approaches emphasizes a person's own contribution to their choices and aims maximize their "full potential."
  - Key components: Some of the key elements of humanistic therapy is goal-setting, focuses on the client as the "expert," and focusing on the here and now.
- Integrative/Holistic: This approach to therapy emphasizes the importance of blending elements of different approaches that best match their client's need.
- Engage in conversation with students using the following questions:
  - Why is it important to know different treatment approaches as students/clients?
  - How do you think you will use this information?

Materials

- Flipchart
- Markers
- Useful information to reference: https://www.apa.org/topics/psychotherapy/approaches

Module 4 Activity 2: What do I do in therapy?

Purpose

- To provide students with a general understanding of what talk therapy can look like.
- To demystify the process of therapy.

Approximate time: 40 minutes

How-To

- Begin by asking students what they have heard about therapy? The process?
- Ask students what their expectations are for a therapy session? What do they think typically happens?
- Explain the typical process of individual mental health services (i.e., beginning, middle, and end)
  - Beginning: Therapists usually begin by what they refer to as an "intake." This can mean various things but typically is focused on gathering more information on the person. For example, their personal history, history of mental health, why they want to seek treatment, have they received treatment before, what their goals are, etc.
  - Middle: This is where people may see the biggest difference. Therapists have different ways of approaching therapy and working with their patients/clients as we talked about in activity 1. This can also range in number of sessions. Some treatments are very structured, and others are not. The important thing here is to be proactive about working with your therapist. Ask them questions and let them know if something isn't working for you. You (the patient/client) can have a say in your treatment. It's part of treatment. We will talk more about *how* to do this in the next module.
  - End: At the end of treatment, there is usually a "termination" session. The termination session typically includes revisiting the client's goals from the intake session and going over the client's overall progress. Therapists may also review any coping tools that have been developed throughout the sessions that the client can access when they are feeling distressed. Termination may also include a range of emotions.
- Ask students to reflect on the process by using the following guiding questions:
  - Is this process similar to other processes you've engaged with?
  - How do you feel about knowing the process of treatment before you were to start therapy?
  - It's important to understand that this can vary and each therapist has their own way of approaching the beginning, middle, and end of any treatment.

Materials

- None (discussion based)

Module 4 Activity 3: Barriers and Facilitators to People Accessing Mental Health (social determinants of mental health)

Purpose

- To explore barriers and facilitators that support youth's access to mental health.
- To understand the various components that contribute to mental health accessibility.

Approximate time: 40 minutes

How-To

- Before beginning by hanging up five flipchart notes around the room. DO NOT LABEL.
- Begin by asking students what encourages what makes a "healthy" community? What elements do communities need in order to be "healthy"?
  - Ask that students write their answers on sticky notes. One answer per note card.
- Label flipchart sheets with the following labels: education, health care, neighborhood & built environment, social & community context, economic stability.
- Ask students to place their sticky notes on one of the flipcharts. If students' examples do not fit under one of these categories, provide an example.
- Explain to students that all of these components influence how people live, work, and play. It affects their overall health and can either be barriers or facilitators (make it easier) for people to access food, education, health care, etc.
  - For example, if students don't have access to transportation, it's difficult to access services.
- Ask students how each of these may contribute to the overall health of people? How is this important to mental health?
- End the session by discussing how they can help. Even though some of these barriers exist, building knowledge and connections (e.g., like the community organization they are participating in) can help them access services.
- How communities help alleviate some of these barriers is different for different communities. Explain to students that you will be going over resources in the next module.

Materials

- Sticky notes
- Pens
- Flipchart
- For reference: https://health.gov/healthypeople/priority-areas/social-determinants-health

Module 5 Preparation

Seeking & Finding Help

Overview

Seeking mental health support is often a process that has a lot of underlying complexity: where do I seek support, when do I seek support, what kind of support exists, what does the process entail, and what do I do once I am getting support?

Notably, experiences with seeking mental health support can vary widely. For example, The US Department of Health and Human Services shared current data of disparities and access to mental health treatment of adolescents in the United States.[13] Thirty-one percent of White youth receive mental health services in comparison to 13% of youth of color. Twenty-one percent of youth aged six to 17 who live in poverty have a mental health disorder. High school-aged youth who identify as lesbian, gay, bisexual, and transgender (LGBT) have a much higher likelihood of thinking about suicide when compared those who identify as heterosexual. Native American youth, at any age, are more likely to die due to suicide than any other ethnic group in the US.[14] It is critical to consider the repercussions of unmet mental health needs of minoritized youth. Geographical location also plays an essential role in accessibility. Rural and low-income counties in the United States have the highest rates of unmet mental health care needs (Yang et al., 2019).[15] While understanding that systemic barriers affect mental health accessibility, providing mental health knowledge to communities can be a crucial component to increasing help-seeking behaviors.

This module is intended to present concerns related to access to treatment, what treatment entails, how to access treatment, and what support is locally available. This module was created to demystify the mental health treatment process and also encourage youth to build a local resource guide for their own social context.

Learning Objectives

In this module students will learn to:

- Understand that there are a range of supports that exist for people (e.g., coping mechanisms, mental health services, crisis intervention)
- Identify support services in their local community context.
- Become familiar with community-based mental health services.

Major Concepts

- Treatment plans can vary depending on treatment modality, severity, and patient needs.
- Mental illnesses, just like physical illness, can be treated
- Exploring local community resources and building a mental health resource bank.

Activities

- Activity 1: Coping Mechanisms
- Activity 2: Building a treatment plan (30 minutes)
- Activity 3: Building a local resource list (30 minutes)
- Activity 4: How to access local resources (30 minutes)

Participatory Component

The participatory components for module 5 are activity 3: *Building a local resource list,* and *4*: *How to access local resources.* These activities are intended to be potential lesson plans for this module but are flexible to youth participants' suggested changes.

- Before beginning activity 1 – show students the layout of module 5. Remind students that they are able to change, modify, or replace.
  - Also ask students what they would want to learn from this module so that the facilitator can adapt as necessary

Module 5 Activity 1: Coping Mechanisms

Purpose

- To explore coping mechanisms that youth can access when they are under particular distress.
- To build a coping mechanism "toolbox".

Approximate time: 30 minutes

How-To

- Ask students if they have heard the term "coping mechanisms" before. Have students share what they have heard about the concept.
  - Write these down on a large flipchart sticky note
- Engage in a live demonstration of a "stress bucket" activity.
  - **NOTE:** facilitator may watch video as an example: https://youtu.be/FrfYcNFKi3A
  - The video does not need to be shown to the group of students
- Fill up a foam cup with water. Make sure you are holding the cup of water over a bucket/tub so the water does not spill on the floor.
- Describe to students that this cup is filled with water and is about to overflow because of how much water it contains. Ask students what their solution to stopping the cup from overflowing.
  - Here students may provide answers such as dumping the water out, creating holes in it, and dumping some of it out. Either way, these are examples of releasing "pressure."
- After students have shared their suggestions, the facilitator can puncture holes in the cup and describe this as releasing pressure and "outlets" for the water to flow through so the cup does not overfill.
- Explain to students that just as holes can be punctured in the water cup to stop the cup from overflowing, coping mechanisms can work the same when people are feeling stressed.
- Provide a description of what a coping mechanism is: any conscious or nonconscious adjustment or adaptation that decreases tension and anxiety in a stressful experience or situation.
- Ask students what they do to alleviate stress that may contribute to their cups not overflowing.
- After students provide examples, the facilitator may also provide commonly used coping mechanisms. Use the list below as examples.
  - Listening to your favorite music
  - Slowing your breathing (4-7-8 breathing technique): breathe in for four seconds, hold it for seven seconds, release for 8 seconds, repeat until best see fit
  - Notice five things in your environment (e.g., colors, the texture of something, the temperature, shapes)
  - Tap your hands on your knees (while sitting) in a steady beat
  - Pretend to squeeze lemons then release them
  - Connect with your community (friends, family, others)
  - Engage in a physical activity (e.g., walking, running, swimming, tennis, soccer)

Materials

- Flipchart + Markers
- A foam cup (or some type of contains that can easily be punctured)
- A tub/ bucket to hold underneath the cup
- Water (can obtain from a sink/facet)

Module 5 Activity 2: Building a Treatment Plan

Purpose

- To introduce students to a treatment plan.
- To demystify the treatment component of mental health treatment.
- To demonstrate to students that they can collaborate with mental health professionals in creating goals for treatment.

Approximate time: 40 minutes

How-To

- Introduce treatment plans to students by explaining the basics of a treatment plan and why it is typically used. Use the below outline of bullet points to explain what a treatment plan is.
  - A treatment plan is a set of written instructions or outline that guides the therapeutic process. Clinicians can vary on the details included in a treatment plan, but most will typically include the following components:
    - The patient's personal history, information, and any diagnoses the person may already have.
    - Definition of the presenting concerns.
    - Treatment goals (can be co-created with clients/patients.
    - Description and general outline of the treatment selected (e.g., cognitive behavioral therapy, dialectical behavioral therapy, solution-focused therapy).
- Place the flipchart sticky notes related to treatment modalities and treatment components on the walls/ board.
- Have students engage in a gallery walk to refresh their memory about treatment plans and components.
- Ask students to return to their seats and get into groups of 2-3.
- Hand out blank pieces of paper, markers, and pens. Have students create a treatment plan based on the scenario presented to them. Pass out the treatment plan scenario handout.
- Read the scenario aloud and the student read along.
- The facilitator should demonstrate and model by creating one of their own using a flipchart.
- Ask students to use the following outline:
  - Personal History:
  - Presenting Concerns:
  - Treatment Goals:
  - Description of treatment selected or common treatment components they want to utilize:
- NOTE: if students do not have a presenting concern, ask them to make a hypothetical scenario. For example, please see treatment scenario handout at the end of this activity.

Materials

- Facilitators can refer the following website for more information on a treatment plan: https://positivepsychology.com/mental-health-treatment-plans/#what-mental-health-plan
- Blank pieces of paper
- Pens, markers, pencils
- Treatment Scenario Handout
- Flip chart sticky notes from module 4, Activity 1
- Blank flipcharts

Example Treatment Scenario

Andres [can replace this name if there is someone in your group of students with the same name] found himself feeling nervous about the beginning of the school year. He is 16 years old and is beginning his junior year of high school and his caregivers have been reminding him that it's soon going to be time to look for a job or go to college.

Both of his parents immigrated to the US prior to Andres being born. His parents work minimum-wage jobs and really emphasize the importance of education. His parents both attended college in Mexico but were unable to secure positions that reflected their higher education in the US.

Andres feels like he doesn't know which direction to go, how to get there, or what he wants to pursue as a career. Because he is feeling overwhelmed, Andres has not searched for answers and is feeling "stuck" as he begins his junior year of high school. He explains to you, the therapist, that he really wants to go to college but is unsure in what area he should focus on and is unsure how to pay for college.

Module 5 Activity 3: Building a Local Resource List

Purpose

- To explore the local mental health resources that youth may have available to them.
- To develop a list of resources for youth, their community, and families.

Approximate time: 30 minutes

How-To

- **NOTE**: This activity will include a guest discussion on local resources. For example, if the curriculum is being implemented in community organizations, staff members may share what resources they are already familiar with in their community. If the curriculum is being implemented in schools, ask a school psychologist or community liaison to share mental health resources that are typically accessed by students. This should be no more than 15 minutes.
- Begin the session by asking students where they would go if they needed mental health services. Ask students if there are other places, they would seek support (e.g., family, friends, community members).
- On a large flipchart sticky note, write the students' responses down.
- Ask students how they might begin looking for support (e.g., asking adults around them, an internet search).
- Let students know that we will be creating a list of local resources that will incorporate what the staff member shared and also an internet search.
- Ask students to get into groups of 2-3 and search "mental health services near me" on google.
    - If students have access to tablets/ computers/ laptops, request that students use these devices to search.
    - If students do not have access to the above, ask students to use their cell phones.
    - If students do not have cell phones, the facilitator may conduct the search on their device and ask students to serve as scribes on flipcharts.
- At the end of the lesson, summarize the resources and let students know that you (the facilitator) will combine the list and bring printed out versions for them to use for the next lesson.
    - Note: If the next lesson is occurring immediately after activity 3, keep the resource list on the flipchart.
- Facilitators may provide also students with a summarized list of resources that already exist for the community, for example: https://www.cottagehealth.org/app/files/public/29dd5190-ebeb-4fae-8162-44f4fbd197cc/Cottage_Health_Coronavirus_COVID_19_Mental_Health_Resources_061521.pdf

Materials

- Flipchart
- Markers

Module 5 Activity 4: How to Access Local Resources

Purpose

- To support youth in knowing *how* to access local mental health resources.
- To develop an outline on how to approach accessing local resources.

Approximate time: 30 minutes

How-To

- Begin by asking students about achieving a goal. When people play sports or are trying to meet another goal, do they only have one way of getting there or several?
- Explain that having several paths to achieving a goal often leads to greater success. The same is true for seeking support.
- Explain to students that support can vary depending on what a person needs.
    - Crisis hotlines exist when someone is in severe crisis and needs immediate support. There are crisis hotline numbers at the end of this manual.
    - During this lesson, we will be talking about accessing local mental health resources.
- Ask students what they think the first step in looking for services might be. Examples here may include, calling the service location, emailing, or going into the place physically.
- Re-affirm any of the responses that the students shared and also let students know that many places have a form you can fill out online.
    - For example, locations like universities and colleges may have a form the potential client may fill out.
    - Many resources also have a function in which a concerned person (e.g., family, friend, teacher, doctor) can refer a person to mental health services.
- Select one of the resources that students located in the previous lesson.
- Demonstrate how you might request services. This may include connecting your computer to a projector or gathering students around a device.
- This activity will include the facilitator going through a website and demonstrating steps that students may use to contact an organization to seek support. Their facilitator does not have to call or email a place of services but demonstrate how they may go about it.

Materials

- Local Resource List Developed from Module 5, Activity 3
- Flipchart
- Markers

Module 6 Preparation

The Importance of Positive Mental Health + Community Healing

Overview

Communities have been healing long before the field of mental health began conceptualizing what is mental health. This module aims to be positive and asset-based in allowing youth to recognize the strengths of their communities in healing and taking care of one another. In addition, this module also emphasizes the importance of resilience and post-traumatic growth (PTG) in order to illustrate that humans can overcome challenges and obstacles.

Learning Objectives

In this module students will learn to:

- Discuss and recognize their community resources and forms of healing.
- Recognize the difference between resilience and post-traumatic growth.

Major Concepts

- Community-specific and youth contextualized ways of healing.
- Communities have their own forms of healing and coping mechanisms that may not be recognized by the field of psychology.
- Understanding resilience and post-traumatic growth.

Activities

- Activity 1: What does healing look like in your context? (Community healing) (30 minutes)
- Activity 2: Understanding resilience and post-traumatic growth + reviewing coping mechanisms (30 minutes)
- Activity 3: Celebration (60 minutes) – should take up the whole last session

Participatory Component

The participatory component for module 6, is activity 1: What does healing look like in your context? These activities are intended to be potential lesson plans for this module but are flexible to youth participants' suggested changes.

- Before beginning activity 1 – show students the layout of module 6. Remind students that they are able to change, modify, or replace.
  - Also ask students what they would want to learn from this module so that the facilitator can modify the curriculum to students' requests.

Module 6 Activity 1: What does healing look like in your context? (Community healing)

Purpose

- To explore students' community ways of healing and caring for each other.

Approximate time: 30 minutes

How-To

- Begin by setting up the conversation by telling students, throughout these lesson plans, we have been discussing how the *field* of mental health approaches healing, coping, and treating mental illness. For this activity, we'll talk about how *your community* and *your family/caregivers* have healed.
- Our communities have been healing for a long time, informally or formally. Today we are going to play a game called "bucket of community knowledge."
- As the facilitator, set up the bucket about 10 feet from where the students are situated. Grab a ping pong ball and provide an example. After you say your example aloud, shoot the ping pong ball in the bucket.
  - Example: My family often gathers around a table with pan dulce and Cafecito talking about family updates or anything. Although this doesn't necessarily talk about our mental health, I always look back at it as something that provided a space for connection and healing.
- Ask students to provide examples and shoot a ping pong in the bucket after they share. If students don't make the ball into the bucket the first time, they can try until they make it inside the bucket.
- After all participating students have taken a turn, show students how "full" the bucket is.
- Wrap up the activity by telling students that communities have their own resources and ways of healing that may not be "formal" mental health supports but it's important to acknowledge that communities and *have already* been healing. They are resourceful. Our communities are resourceful.

Materials

- Large Bucket (at least about a gallon)
- Ping pong balls

Module 6 Activity 2: Post-traumatic Growth + Reviewing Coping Mechanisms

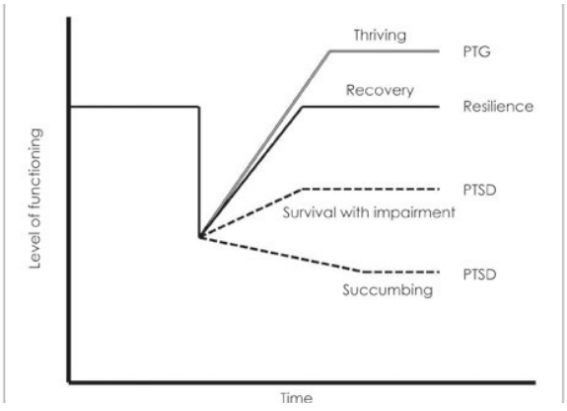
Purpose

- To provide a basic understanding of resilience of post-traumatic growth.
- To understand the difference between resilience and post-traumatic growth.

Approximate time: 30 minutes

How-To

- Transition students from the previous lesson to activity 2 by letting students know that because communities have their own ways of healing, potentially without accessing mental health resources, they are resilient.
- Place two flip charts in the space and label one resilience and the other post-traumatic growth. Ask students what they have heard about these two concepts and record their answers on the flipchart.
- Illustrate to students by using some sort of ball that can bounce.
  - Resilience: Have one student volunteer. Call them the "baseline" and let's pretend the bouncy ball is a person. Hand them the bouncy ball and ask them to bounce it on the floor and catch it when it comes back up to their hands. After they have completed the task, tell students that this illustrates resilience and the "bounce back" effect. Explain that the baseline was the student's hands and then the ball dropping is something happening, like a traumatic event, and the ball "bouncing back" to the student's hands is the person (i.e., the ball) is returning to their baseline that existed before the event.
  - Post-traumatic Growth: Ask an additional student to volunteer. Have one student bounce the ball to the other student. Tell students that this illustrates PTG. An event, when the ball hits the ground, occurs and the ball doesn't return to baseline (the original student that had it) but goes beyond the baseline and may "thrive" despite the event.
- At the end of this activity, draw the following diagram on a white board or flipchart. Highlighting the resilience and PTG portions of the graph.



- To wrap up, let students know that this is of course more complicated than just illustrated but the main difference between the two is that resilience refers to "bouncing back" while PTG refers to "thriving" past the original baseline.
- Remind students that people and communities are able to be resilient and demonstrate PTG because they have coping mechanisms like the examples we reviewed in module 5, activity 1.
- Ask students to share some coping mechanisms. If they do not have any examples, share some of the coping mechanism examples in module 5, activity 1:
  - Listening to your favorite music
  - Slowing your breathing (4-7-8 breathing technique): breathe in for four seconds, hold it for seven seconds, release for 8 seconds, repeat until best see fit
  - Notice five things in your environment (e.g., colors, the texture of something, the temperature, shapes)
  - Tap your hands on your knees (while sitting) in a steady beat
  - Pretend to squeeze lemons then release them
  - Connect with your community (friends, family, others)
  - Engage in a physical activity (e.g., walking, running, swimming, tennis, soccer)
- To complete the session, let students know that the next session is the final session and there will be a celebration.

Materials

- Some type of bouncy ball
- Flip chart

Module 6 Activity 3: Celebration

Purpose

- To celebrate the completion of the program. (:

Approximate time: 60 minutes (the final day of the program – should take up the whole meeting time)

How-To

- Let students know that they have completed the program and hold space for any reflections from anyone (i.e., facilitators, students, supporters).
- If there are any expected individual interviews or check-out sessions with students, let them know when they will occur.
- Provide snacks, music, fun games (e.g., kick ball, corn hole, soccer, tik tack toe, hang man).

Materials

- Any materials needed for the given fun activity the facilitator/ youth have chosen.

Template Activity Outline

Activity Outline: This outline can be used for any additional or replacement lesson plans that the community and/or youth request.

Module [x]

Activity #[x]

Activity [Number]: [Title]

Purpose

- [Includes the goals of the lesson and what the youth and/or the facilitator hope to gain from the lesson]

Approximate time: [includes the approximate time]

How-To

- [Includes a detailed outline that can be utilized by any facilitator]
- [May include guiding questions if more discussion-based]
- [May also include notes/tips for the facilitator]
  - If this is the case – clearly note

Materials

- A list of any materials the facilitator may need to obtain prior to implementing the lesson plan

National Resources

Substance Abuse and Mental Health Service Administration (SAMHSA) Number

- SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.
- 1-800-662-4357 (HELP)

National Suicide Hotline 24/7

- Text or Call 988

Trevor Project

- Crisis counselors are trained to answer calls, chats, or texts from LGBTQ young people who reach out on our free, confidential and secure 24/7 service when they are struggling with issues such as coming out, LGBTQ identity, depression, and suicide.
- Via online chat, call, and text
- https://www.thetrevorproject.org/get-help/?gclid=CjwKCAjw1ICZBhAzEiwAFfvFhMf_O6DRx96Uba3U0U0IBvay8BKeAk8xpPK6yC490QahtI5kyhsWqxoCaCkQAvD_BwE
- Text "Start" to 678-678
- Call 1-866-488-7386

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Appendix C. IRB Documents

YPEAM Parent Consent – English

Summary of Key Information:

The present program aims to evaluate the effectiveness of Youth Participatory and Engagement and Action in Mental health (YPEAM), a new mental health promotion program. It is a curriculum-based mental health program that will be delivered across 6 weeks. YPEAM is one of many after school programs that the YMCA is offering this academic year. Please refer to the curriculum parent outline linked at the beginning of this consent. This is not group therapy, but it involves learning about mental health in a group setting with other youth between the ages of 12-17 years old. It is designed to teach youth about mental health. It is a research project being run by a UCSB psychology graduate student with 3 years of mental health training and experience. Youth will be asked to do the following:

- Participate in 12 session across 6 weeks
- Complete short surveys (please see the procedures section for more information)
- An interview at the end of the 12 sessions to share their experience
    - Interviews will be scheduled within two weeks of completing the program

The research project involved implementing the YPEAM program and evaluating it. Although not guaranteed, it is likely that your child will greatly benefit from better understanding topics related to mental health. Other similar programs have demonstrated improvements in youth well-being after participating in a mental health knowledge program. Please refer to the curriculum outline for further information.

Purpose:

Your child is being asked to participate in a research study. The purpose of the study is to implement a new curriculum to teach youth about mental health.

Procedures:

If you decide to allow your child to participate, a group of youth from the YMCA will meet twice a week, with the adult facilitator (Natalie Larez), for an1.5 hours for 6 weeks of the YPEAM program. YPEAM will be offered as one of the after-school program options at the YMCA. The curriculum materials can be found as a link at the beginning of this consent form. Participation also includes taking several surveys and questionnaires and participating in an interview as described below:

- One survey with 10 questions, about and stigma before and after the program.
- A post-session 5-minute survey after each weekly session.
- A 5-minute mental health knowledge questionnaire will be administered at the beginning and end of each module. There are 6 modules.
- One 1-hour interview at the end of the YPEAM program. Interviews will be conducted

after completion of the 6-week program. This interview will be recorded so that researchers can accurately reflect your child's thoughts about the curriculum. Recordings will not be shared with the YMCA.

- The total time commitment of this project is 9 weeks. This includes 6 weeks of the program plus their individual interview scheduled within 2 weeks of completion of the program.

Alternatives

If you and your child decided that you do not want them to participate in this program, the YMCA has other after-school programs available. Please contact the coordinator with more options.

Risks

The researchers have training in maintaining participant confidentiality within group contexts. Researchers will explain to your child and all other participants the importance of keeping what is said private and only sharing summary information that the group agrees to share. Researchers will also explain all the limits to confidentiality. The limits include mandated reporting for disclosures of harm. There is also risk of potential feelings of distress when discussing topics around mental health and stigma. The facilitator is trained in risk management, de-escalation, and psychological techniques that can support students when experiencing distress. The literature was also consulted in appropriate methods to deliver mental health knowledge. Students will have an opportunity to debrief after each session regarding any feeling that may have come up for them. Please see the confidentiality section for further information regarding mandated reporting.

Benefits

This type of research engages youth participants in learning about mental health through activities, discussions, and presentations. While no benefit is guaranteed, it is likely that your child will learn more about mental health, how to access mental health, and components that influence mental health. Other mental health knowledge curriculum has shown great promise in improving the well-being of youth.

Confidentiality

Any data collected will be stored in a locked research office or in a password protected online platform. Additionally, any files with your child's identifiable information, such as their name, will be kept in a password protected USB and the USB will be in a locked research office when not in use. The results of this research may be presented at a conference, published in a scientific journal, or shared with other researchers. Privacy will be maintained when results are shared. Your child's identity will not be made known in written materials resulting from this study. Audio files will be uploaded to a transcription service. Audio recordings will only be shared by including quotes, but your child's identity will be protected. Although youth will be reminded to not use their name or any other youth's name while interviewing, it is possible that they accidently disclose a name. If this becomes the case, any names will be removed from the transcription in an effort to protect their privacy. All audio files will be destroyed after the project is complete. Your child's identity will not be made known in written materials resulting from this study. Third party platforms used to store the interview audio file may have access to the recordings under their privacy policy. Audio files will not include your child's name or identifiable information.
Under California law, we will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If your child discloses that that they are thinking of hurting themselves or others, we are legally obligated to break confidentiality. We are also obligated to break confidentiality if your child discloses, they are having sexual relationship with someone much older than them. For example, if you child is 14 and dating or having sex with someone who is 21 years old, this must be reported. If any member of the program staff has or is given such information, they will be required to report it to the agencies (e.g., child welfare services).

Costs/Payment

Your child may occasionally receive food or snacks. Your child will be paid $15 for completing the 5-minute survey at the end of every session (total 12 sessions) via gift cards. They will also be paid $15 for the 45 – 60-minute final interview. Youth will be paid at the end of each week, receiving $30 a week if they completed both sessions. Youth are encouraged to stay the full 1.5 hours for each session. If your child needs to leave during the session, they can still receive the $15 as long as you complete the survey for that day. If you/ your child decides to no longer participate in YPEAM, your child will no longer be paid but will be paid for their previous sessions as discussed above.

Rights to Refuse/Withdraw

Your child may refuse to participate and still receive any benefits they would receive if they were not in the study. You may change your mind about being in the study and remove your child after the study has started.

Contact Information

If you have any questions about this research project or if you have any questions or concerns about your rights and treatment as a research subject, please contact: Natalie Larez, nalarez@ucsb.edu, 805-364-0150 or Jill Sharkey, jsharkey@education.ucsb.edu, 805-893-3441

If you have any questions regarding your rights and participation as a research subject, please contact the Human Subjects Committee at (805) 893-3807 or hsc@research.ucsb.edu. Or write to the University of California, Human Subjects Committee, Office of Research, Santa Barbara, CA 93106-2050

Parent name (print): _____ Parent/guardian signature: _____

Youth/Child name (print): _____

YPEAM Youth Assent - English

Summary of Key Information:

The present program aims to determine the success of Youth Participatory and Engagement and Action in Mental health (YPEAM), a new mental health education program. It is a mental health program that will be delivered across 6 weeks. YPEAM is one of many after school programs that the YMCA is offering this academic year. This is not group therapy, but it involves learning about mental health in a group with other youth between the ages of 12-17 years old. It is designed to teach youth about mental health, and you are not required to share personal information but can if you would like/see it as helpful. It is a research project being run by a UCSB psychology graduate student with 3 years of mental health training and experience. You will be asked to do the following:

- Attend 12 sessions across 6 weeks
- Complete short surveys (please see the procedures section for more information)
- An interview at the end of the 6 weeks to share your experience

Although not guaranteed, it is likely that you will greatly benefit from better understanding mental health topics. Other similar programs have shown improvements in youth well-being after participating in a mental health knowledge program. You will be paid for your participation.

Purpose:

You are being asked to participate in a research study. The purpose of the study is to carry out a new program that has a goal to teach youth about mental health. We also want to know how successful it is which is why we use the questionnaires/ surveys.

Procedures:

If you decide to participate in the program, you will participate in an hour and a half program twice a week for 6 weeks. The program will take place after school at the YMCA. During this program, you will work in a group with 9 other students who are 12 to 17 years old. Program activities include playing games or hands-on activities and engaging in conversation that are designed to help you learn more about mental health. YPEAM will be offered as one of the after-school program options at the YMCA. To understand how the program is going, we will also ask you to complete the following surveys:

- One survey with 10 questions about and stigma before and after the program.
- A 5-minute survey after each session.
- A 5-minute mental health knowledge questionnaire will be administered at the beginning and end of each module. There are 6 modules.
- One 1-hour interview at the end of the YPEAM program. Interviews will be conducted
  after completion of the 6-week program. This interview will be recorded so that researchers can accurately reflect your child's thoughts about the curriculum. Recordings will not be shared with the YMCA.
- The total time commitment of this project is 9 weeks. This includes 6 weeks of the program plus time for your interview.

Alternatives

If you decide that you do not want them to participate in this program, the YMCA has other after-school programs available. Please contact the coordinator with more options. Even

though your guardian/parent may have agreed to your participation, this is still a voluntary process, and you may decide to not be a part of this program at any point. You are allowed to stop participating in YPEAM at any point, without penalty and it will not affect your ability to be a part of the YMCA. If you decide to stop participating at any point, you may still access other after school programs.

Risks

The researchers have training in maintaining participant confidentiality within group contexts. Researchers will explain to your child and all other participants the importance of keeping what is said private and only sharing summary information that the group agrees to share. Researchers will also explain all the limits to confidentiality. The limits include mandated reporting for disclosures of harm. There is also risk of potential feelings of distress when discussing topics around mental health and stigma. The facilitator is trained in risk management, de-escalation, and psychological techniques that can support students when experiencing distress. The literature was also consulted in appropriate methods to deliver mental health knowledge. Students will have an opportunity to debrief after each session regarding any feeling that may have come up for them. Please see the confidentiality section for further information regarding mandated reporting. Youth should be aware that adult facilitators will aim to protect your confidentiality but since it is a group setting, other youth will hear your stories and may share them outside of the group. The adults will do their best to always remind youth to please protect the privacy of other students.

Benefits

This type of research engages youth in learning about mental health through activities and discussions. While no benefit is guaranteed, it is likely that you will learn more about mental health, how to seek help about your mental health, and what influences mental health. Other mental health knowledge programs have shown the positive effects on youth.

Confidentiality

Any information collected will be stored in a locked research office or in a password protected online platform. Additionally, any files with your identifiable information, such as your name, will be kept in a password protected USB and the USB will be in a locked research office when not being used.

The results of this research may be presented at a conference, written up for research, or shared with other researchers. Privacy will be maintained when results are shared. Your identity will not be made known in written materials. Individual Interviews will be recorded with no identifying information which means that we will not use your name in the interview, and we will verbally remind you to not use your own name or of other youth. Audio files will be uploaded to a platform that changes audio to words. Audio recordings will only be shared by including quotes, but your identity will be protected. All audio files will be destroyed after the project is complete.

Under California law, we will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, physical, sexual, emotional, and financial abuse or neglect. If you share that that you are thinking of hurting yourself or others, we have to break confidentiality. Additionally, if you are in a relationship with someone much older than you, we also must notify the appropriate agencies. For example, if you are 14 and dating someone who is 21 years old, the state considers this something that needs to be reported. If any member of the

program staff has or is given such information, they will be required to report it to the appropriate agencies.
Additionally, although adult facilitators will aim to protect your confidentiality and privacy, there is a risk of sharing your own personal information in a group setting with other youth. It is possible that other youth may hear your story and share them outside of the group. In order to add additional protections, the adult facilitator will remind students to protect each other's privacy and not share others' personal stories outside of the YPEAM setting.

Costs/Payment

You may occasionally receive food or snacks. You will be paid $15 for completing the 5-minute survey at the end of every session (total 12 sessions) via gift cards. You will also be paid $15 for the 45 – 60-minute final interview. Youth will be paid at the end of each week, receiving $30 a week if they completed both end-of-session survey. Youth are encouraged to stay the full 1.5 hours for each session. If you need to leave during the session, you can still receive the $15 as long as you complete the survey for that day. Some examples of leaving the session may include leaving for a doctor's appointment, school function, or if what we are discussing in the session becomes too uncomfortable. If you/ your guardian decides to no longer participate in YPEAM, your child will no longer be paid but will be paid for their previous sessions as discussed above.

Rights to Refuse/Withdraw

You may refuse to participate and still remain part of the YMCA and select a different after-school program to join. There will be no penalty if you decide to remove yourself as a youth participant. You may change your mind about being in the study and stop participation in YPEAM after the program has started.

Contact Information

If you have any questions about this research project or if you have any questions or concerns about your rights and treatment as a research subject, please contact:
Natalie Larez, nalarez@ucsb.edu, 805-364-0150 or Jill Sharkey, jsharkey@education.ucsb.edu, 805-893-3441
If you have any questions regarding your rights and participation as a research subject, please contact the Human Subjects Committee at (805) 893-3807 or hsc@research.ucsb.edu. Or write to the University of California, Human Subjects Committee, Office of Research, Santa Barbara, CA 93106-2050

This is part of a research study being conducted through the University of California, Santa Barbara.

Youth Participatory Engagement & Action in Mental Health (YPEAM)

A group where you can learn more about mental health and engage in fun activities with friends.

- Are you/ is your child between the ages of 12 - 17 years old?
- Interested in learning more about mental health?

If the answer is "yes" then your child is eligible to participate!
Please scan the QR code to access an outline of the curriculum and share information to contact you.

This group will be led by Natalie Lárez, a school psychologist in training. It is not intended to be group therapy but does provide a safe place to learn and talk in a group setting.

Compensation includes: $15 per completion of each after-session survey via gift card. YPEAM involves:

- 12 group sessions
- 1 interview

https://ucsb.co1.qualtrics.com/jfe/form/SV_39ONJyZ9JvTBrj8

If interested or have questions, please contact Natalie Larez at:

520-220-1514
nalarez@ucsb.edu

When? Where?
Tuesdays & Thursdays
4:30 pm to 6 pm
St. George YMCA | Goleta, CA

Youth Participatory Engagement and Action in Mental Health (YPEAM)

If you have any questions or would like to set up a meeting to discuss the curriculum, please feel free to contact Natalie Lárez at 520-220-1514 or nalarez@ucsb.edu.

Si tiene alguna pregunta sobre el plan de estudios, por favor de comunicarse con Natalie Lárez a 520-220-1514 o nalarez@ucsb.edu.

Natalie Larez, M.Ed.
UNIVERSITY OF CALIFORNIA, SANTA BARBARA
HEALTH POLICY RESEARCH SCHOLARS, ROBERT WOOD JOHNSON FOUNDATION

SUPPORT: BRITNEY WALTON, ISAAC BOUCHARD, JILL D. SHARKEY, PHD

English Parent Outline

About the Curriculum

YPEAM is a group-delivered, mental health promotion program designed to increase mental health knowledge in a group setting to provide flexibility and adaptability that reflects the students' needs. YPEAM is curriculum-based intervention which includes the following six modules: a) understanding mental health, b) Stigma of Mental Illness, c) Information on specific mental illnesses, d) Therapy approaches, process, and critiques, e) Seeking and finding support, f) seeking help and finding support, and g) The importance of positive mental health + Community healing. This curriculum was created for the delivery to adolescents between the ages of 12 – 17 years old with the support of adult facilitators. The curriculum will be delivered through 12 sessions. This is not group therapy but is intended to deliver information on mental health in a group setting. The goal of the curriculum is for youth to learn more about mental health, so they are able to recognize symptoms and know how to find support within their community. Research has shown that when youth know more about mental health, they are more likely to seek help.

Modules In the table below, please find an outline of the modules, major concepts discussed in each module, and each activity within each module.

Module	Major Concepts	Activities/ Lessons
Module 1: Understanding Mental Health	• Everyone experiences mental health, regardless of mental health diagnoses or illness. • Understanding what mental health is and various contributors to its development. • Humans experience a stress response	Rapport Building Activities Activity 1: Mental Health and Mental Illness Activity 2: What is trauma?
Module 2: Stigma of Mental Illness	• Mental health development, treatment, and treatment access is influenced by complex biological and socioenvironmental factors. • Stigma can often act as a barrier for communities and individuals who need treatment. • Understanding stigma, mental health, stereotypes, and misconceptions can help demystify and dispel mental health stigma.	Activity 1: Defining stigma Activity 2: Substance use and mental health Activity 3: Community perceptions about mental illness + Substance use Activity 4: Reducing Stigma

Module	• Major Concepts	Activities/ Lessons
Module 3: Information on specific mental Illness	• Mental illness presentation can vary depending on a person's biology, environment, and access to resources. • There are mental illnesses that are more common than others. • Mental health symptoms can co-occur with other mental health symptoms. • Mental illnesses can be treatable.	Activity 1: Common mental health symptoms and mental illness in adolescents Activity 2: Mental health and mental illness in media Activity 3: Cultural considerations of mental health symptom presentation
Module 4: Therapy approaches, process, and critiques	• Overview of the most common treatment modalities (e.g., cognitive-behavioral therapy, acceptance, and commitment therapy). • Understanding the typical format of therapy. • Social, cultural, economic, and environmental factors influence the development of mental health challenges and influence an individual's access, quality, and perception of mental health services.	Activity 1: Learning about common treatment modalities Activity 2: What do I do in therapy? Activity 3: Barriers and Facilitators to people accessing mental health
Module 5: Seeking Help & Finding Support	• Treatment plans can vary depending on treatment modality, severity, and patient needs. • Understanding treatment plans. • Exploring local community resources and building a mental health resource bank.	Activity 1: Coping Mechanisms Activity 2: Building a treatment plan Activity 3: Building a local resource list Activity 4: How to access local resources

Module 6: The importance of positive mental health + Community healing	• Community-specific and youth contextualized ways of healing. • Communities have their own forms of healing and coping mechanisms that may not be recognized by the field of psychology. • Understanding resilience and post-traumatic growth.	Activity 1: What does healing look like in your context? (Community healing) Activity 2: Understanding resilience and post-traumatic growth

Resumen de actividades en Español

Acerca del currículo. YPEAM es un programa de promoción de la salud mental entregado por grupos diseñado para aumentar el conocimiento de la salud mental en un entorno grupal para proporcionar flexibilidad y adaptabilidad que refleje las necesidades de los estudiantes. YPEAM es una intervención basada en el currículo que incluye los siguientes seis módulos: a) comprensión de la salud mental, b) estigma de la enfermedad mental, c) información sobre enfermedades mentales específicas, d) enfoques, procesos y críticas de terapia, e) buscar y encontrar apoyo, f) buscar ayuda y encontrar apoyo, y g) la importancia de la salud mental positiva + curación comunitaria.

Este currículo fue creado para la entrega a adolescentes entre las edades de 12 a 17 años con el apoyo de facilitadores adultos. El plan de estudios se impartirá a través de 12 sesiones. Esto no es terapia de grupo, pero está destinado a proporcionar información sobre la salud mental en un entorno grupal. El objetivo del currículo es que los jóvenes aprendan más sobre la salud mental, para que puedan reconocer los síntomas y saber cómo encontrar apoyo dentro de su comunidad. La investigación ha demostrado que cuando los jóvenes saben más sobre la salud mental, es más probable que busquen ayuda.

Módulos: En la siguiente tabla, encontrará un resumen de los módulos, los conceptos principales discutidos en cada módulo y cada actividad dentro de cada módulo.

Módulo	Conceptos principales	Actividades/ Lecciones
Módulo 1: Comprender la salud mental	• Todos tenemos salud mental, independientemente de los diagnósticos o enfermedades de salud mental. • Comprender qué es la salud mental y varios contribuyentes a su desarrollo.	Actividades de construcción de relaciones Actividad 1: Salud mental y enfermedad mental Actividad 2: ¿Qué es el trauma?
Módulo 2: Estigma de la enfermedad mental	• El desarrollo de la salud mental, el tratamiento y el acceso al tratamiento están influenciados por factores biológicos y social complejos. • El estigma a menudo puede actuar como una barrera para las comunidades y las personas que necesitan tratamiento. • Comprender el estigma, la salud mental, los estereotipos y los conceptos erróneos puede ayudar a desmitificar y disipar el estigma de la salud mental.	Actividad 1: Definir el estigma Actividad 2: Uso de sustancias y salud mental Actividad 3: Percepciones de la comunidad sobre las enfermedades mentales + Uso de sustancias Actividad 4: Reducir el estigma

Módulo	Conceptos principales	Actividades/ Lecciones
Módulo 3: Información sobre enfermedades mentales específicas	• La presentación de la enfermedad mental puede variar dependiendo de la biología, el entorno y el acceso a los recursos de una persona. • Hay enfermedades mentales que son más comunes que otras. • Los síntomas de salud mental pueden coexistir con otros síntomas de salud mental. • Las enfermedades mentales pueden ser tratables.	Actividad 1: Síntomas comunes de salud mental y enfermedad mental en adolescentes Actividad 2: Salud mental y enfermedad mental en los medios Actividad 3: Consideraciones culturales de la presentación de síntomas de salud mental
Módulo 4: Enfoques terapéuticos, procesos y críticas	• Descripción general de las modalidades de tratamiento más comunes (p. ej., terapia cognitivo-conductual, terapia de aceptación y compromiso). • Comprender el formato típico de la terapia. • Los factores sociales, culturales, económicos y ambientales influyen en el desarrollo de los desafíos de salud mental e influyen en el acceso, la calidad y la percepción de los servicios de salud mental de un individuo.	Actividad 1: Aprender sobre las modalidades comunes de tratamiento Actividad 2: ¿Qué hago en terapia? Actividad 3: Barreras y facilitadores para que las personas accedan a la salud mental
Módulo 5: Buscar ayuda y encontrar apoyo	• Los planes de tratamiento pueden variar según la modalidad de tratamiento, la gravedad y las necesidades de cada persona. • Comprender los planes de tratamiento. • Explorar los recursos de la comunidad local y construir un banco de recursos de salud mental.	Actividad 1: Mecanismos de afrontamiento Actividad 2: Elaborar un plan de tratamiento Actividad 3: Crear una lista de recursos locales Actividad 4: Cómo acceder a los recursos locales

Módulo 6: Importancia de la salud mental positiva + Sanación comunitaria	• Formas de curación específicas de la comunidad y contextualizadas por los jóvenes. • Las comunidades tienen sus propias formas de curación y mecanismos de afrontamiento que pueden no ser reconocidos por el campo de la psicología.	Actividad 1: ¿Cómo se ve la sanación en tu contexto? (Sanación comunitaria) Actividad 2: Comprender la resiliencia y el crecimiento postraumático

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