



Hispanic Immigrant Youth: Struggling to Succeed

Qualitative and Quantitative Results of the *Bienvenido* Program across the Goshen and Elkhart Community School Corporations in Elkhart County, Indiana

2023



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TABLE OF CONTENTS

Table of Contents..... *i*

Abstract *iv*

Introduction **1**

Brief Background on the Bienvenido Program..... **1**

Study Aims **2**

Methods **3**

Study Design **3**

 Quantitative 3

 Qualitative – Focus Groups & Interviews 3

 Qualitative – Content Analysis 3

Sample..... **3**

 Quantitative – Statistical Data 3

 Qualitative – Focus Groups & Interviews 6

 Qualitative – Content Analysis 7

Data Collection Procedures **7**

 Quantitative 7

 Qualitative – Focus Groups & Interviews 8

 Qualitative – Content Analysis 8

Instruments..... **8**

 Quantitative – Statistical Data 8

 Quantitative – Open-ended Questions..... 9

 Qualitative – Focus Groups & Interviews 9

Analysis..... **9**

 Quantitative – Statistical Data 9

 Quantitative – Open-ended Questions..... 10

 Qualitative – Focus Groups and Interviews 11

 Qualitative – Content Analysis 12

Results **13**

Quantitative – Statistical Data **13**

 Question 1. What factors predict pre-test scores for depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities,

behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes? 17

Question 2. Are there changes across students in depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes from pre-test to post-test and from pre-test to follow-up? 18

Question 3. Are there changes in mental and behavioral health indicators among cohorts of participants according to education level (e.g., freshman class and high school students)? 20

Quantitative – Open-ended Questions **24**

 Frequency Analysis 24

 Salience Analysis 33

 Summary of Findings – Open-ended Questions 40

Qualitative – Focus Group & Interviews **41**

 Administrators 41

 Youths 44

Qualitative – Content Analysis **46**

Discussion **48**

Substance Abuse **48**

Depression **50**

Recommendations **52**

Limitations **57**

Conclusion **58**

References **59**

Appendices **61**

APPENDIX A: PARTICIPANT SURVEY UTILIZED IN THE BIENVENIDO PROGRAM **61**

APPENDIX B: FOCUS GROUP AND INTERVIEW QUESTIONS FOR ADMINISTRATORS AND STUDENTS **63**

APPENDIX C: THE STRESSORS REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT **67**

APPENDIX D: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT **68**

APPENDIX E: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT **69**

APPENDIX F: THE STRESSORS REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT. **70**

APPENDIX G: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT..... 71

APPENDIX H: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT 72

APPENDIX I: THE STRESSORS REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT 73

APPENDIX J: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT..... 74

APPENDIX K: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT..... 75

APPENDIX L: LINE-BY-LINE CODES FROM THE ADMINISTRATORS’ DATASET (SCHOOL CORPORATION STAFF AND BIENVENIDO PROGRAM STAFF), DEVELOPED FROM TWO FOCUS GROUPS AND TWO ONE-ON-ONE INTERVIEWS; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE..... 76

APPENDIX M: LINE-BY-LINE CODES FOR THE STUDENTS’ DATASET, DEVELOPED FROM ONE FOCUS GROUP AND TWO ONE-ON-ONE INTERVIEWS; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE..... 80

APPENDIX N: FOCUSED CODES OF ADMINISTRATORS, DISCUSSED IN RELATION TO THE BIENVENIDO PROGRAM..... 82

APPENDIX O: FOCUSED CODES OF STUDENTS, DISCUSSED IN RELATION TO THE BIENVENIDO PROGRAM..... 85

APPENDIX P: LINE-BY-LINE CODES FROM THE DE-IDENTIFIED NOTES DEVELOPED FROM THE TWO SOCIAL WORKERS INVOLVED IN THE BIENVENIDO PROGRAM; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE..... 87

APPENDIX Q: DEMOGRAPHICS OF ADULT PARTICIPANTS INVOLVED IN THE BIENVENIDO PROGRAM AS REPORTED IN THE BIENVENIDO PRE-TEST SURVEY INSTRUMENT 94

APPENDIX R: SAMPLE OF ADULT PARTICIPANTS THAT PARTICIPATED IN THE BIENVENIDO PROGRAM AND THAT RECEIVED INDIVIDUALIZED SUPPORT SESSIONS 95

APPENDIX S: THE STRESSORS REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT 96

APPENDIX T: COPING MECHANISMS REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT 97

APPENDIX U: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT 98

ABSTRACT

As an outreach initiative, the Northern Indiana Hispanic Health Coalition (NIHHC) began offering the *Bienvenido* “Welcome” program during the school day in January 2022 in Elkhart County, Indiana to respond to the recent increase of Hispanic/Latinx immigrant youth (age 12 and older) arriving in the school system who lacked guidance on integration and acculturation processes. The *Bienvenido* program has been offered by NIHHC for over 10 years among adult and youth Hispanic/Latinx immigrants. It includes a nine-session curriculum. Individualized support sessions were offered as an extension of the program to students identified as in need of additional education. Using qualitative and quantitative methods, we examined two dimensions of the *Bienvenido* program as implemented in the Goshen and Elkhart Community School Corporations, including 1) the impact of the program and 2) the state of participants in the program. We used five different data sources to explore these aims:

1. We conducted a quantitative statistical analysis using survey items to assess mental and behavioral health indicators at three different time points (i.e. pre-intervention, post-intervention, and follow-up).
2. We categorized, quantified, and analyzed three open-ended questions completed by participants at three different time points. The questions asked participants to generate a list of things that caused them stress and associated coping strategies.
3. We conducted two focus groups and one one-on-one interview with the author of the curriculum, EL teachers, a parent liaison, social workers who facilitated the individualized support sessions, and other coordinators associated with implementation of the program.
4. We conducted a focus group with six students from Goshen High School who participated in the *Bienvenido* program.
5. We conducted a qualitative ‘content’ analysis based on de-identified and consolidated notes from social workers who conducted individualized support sessions with a selection of participants.

The results of the multi-pronged analysis indicated positive experiences with the program, provided concrete suggestions for improvement in organizational structure, and outlined serious concerns with the mental and behavioral health of participants, particularly in the absence of additional support and follow-up at the school corporations. An important result was the identification of the intense struggles students face and the lack of resources and support to assist students in overcoming challenges. Overall, the main recommendations include the following:

1. provide follow-up individualized support sessions to participants after the program’s completion;
2. allocate more time for *Bienvenido* class sessions to allow for deeper discussion on the topics;
3. invest in hiring additional staff or training existing staff to address participants’ significant mental health issues and normalize mental health care; and
4. increase familial support by innovating novel ways to include parents and guardians in the program.

INTRODUCTION

Brief Background on the Bienvenido Program

Addressing the mental health of Hispanic/Latinx immigrant children, adolescents, and adults in the United States is essential. Structural barriers such as the lack of linguistically and culturally effective services, lack of health insurance, high cost of care, transportation challenges, stigma, and housing instability, among others, serve as obstacles to accessing mental health services and contribute to disparate outcomes. To improve accessibility to services and mental health outcomes, the Northern Indiana Hispanic Health Coalition (NIHHC) chose to implement the *Bienvenido* (“Welcome”) program, a strengths-based mental health promotion program that focuses on building the emotional and behavioral health of Latinx immigrant youth and helps reduce the risk of reliance on maladaptive coping strategies. The nine Spanish-language sessions cover topics such as substance use, suicide, mental health, coping strategies, and acculturation strategies. The sessions were facilitated by certified Bienvenido facilitators, the majority of whom were community health workers, and licensed social workers throughout a nine-week period at one middle school and two high schools in Elkhart County, Indiana. As an extension of the program, the social workers conducted individualized support sessions with youth identified by teachers and school administrators as in need of additional education. Extra support sessions were provided based on recommendations by the facilitators or based on the observations of social workers.

The local school corporations in Elkhart County are currently experiencing a massive influx of Latinx immigrants. In the last few months of 2021 and 2022, two to three new immigrant students arrived every week at each of the schools participating in the study. The majority of these students are asylum seekers from Honduras, Mexico, and El Salvador. According to school staff, many youths are subject to significant trauma due to their immigration journey, some of them arriving via *La Bestia* (freight trains known as “The Beast” that run through Mexico to the U.S. border) and staying at detention centers at the border.

In general, to be bonded or paroled out of immigration detention, individuals need to provide Immigration and Customs Enforcement officials with evidence that they have a sponsor – someone who is a citizen or permanent resident of the United States, often a family member or friend, who is willing to support them upon their release from custody. The anxiety and uncertainty of meeting a “sponsor,” whom, in many cases, they have never met, plus the extreme danger, abuse, violence, and death that many face during their immigration journey, on top of the homesickness due to separation from family, make these youth a vulnerable population for mental health issues.

Upon arrival in the United States, without knowledge of the language, culture, or country, and often living with an unknown guardian, immigrant youth often face feelings of isolation, homesickness, confusion, and anger. Meanwhile, youth do not receive any training or education regarding cultural norms and acculturation in the United States, nor guidance on appropriate integration strategies in their county, community, or school. In addition, they are placed in a school and grade based on their age, without consideration of their last year of schooling completed. The sessions included in the Bienvenido program focus on normalizing mental health education, acknowledging experiences affecting mental health, creating a supportive peer network, and increasing awareness of behavioral risks and assets. Participants learn stress management techniques, acculturation strategies, communication skills, and more to improve their quality of life and become empowered members of the Latinx community in Northern Indiana and specifically in the cities of Goshen and Elkhart in Elkhart County.

Study Aims

Using qualitative and quantitative methods, we examined three dimensions of the Bienvenido program, by assessing:

Aim #1. The impact of the program on immigrant youth who participated in the Bienvenido program, as well as the impact of the program on the wider community;

Aim #2. The state of participants in the program, specifically, their level of acculturation, mental and behavioral health, and academic self-efficacy.

Our goal was to create a set of recommendations that will inform best practices for continued implementation of the Bienvenido program, as well as short- and long-term support of immigrant youth at middle schools, high schools, and immigrant-oriented community locations across Northern Indiana.

METHODS

Study Design

A mixed-methods study using quantitative and qualitative data was conducted.

Quantitative

In the quantitative methods, we used a longitudinal study design, surveying participants using a survey tool pre-intervention at the beginning of Session #1, post-intervention at the end of Session #9, and approximately three weeks follow-up. The survey tool was the same one used at pre-, post-, and follow-up time periods; all questions were identical across time periods. We performed statistical analysis on data collected from multiple-choice questions. For three open-ended questions, we performed frequency analysis and salience analysis, which combines frequency and order of mention.

Qualitative – Focus Groups & Interviews

Qualitative methods included focus groups and one-on-one interviews. Analysis of this data was based on a constructed grounded theory approach (Charmaz, 2006) to explore 1) school administrators' experiences implementing the program and interacting with newly-arrived immigrant youth; 2) the Bienvenido program facilitator's and assistant's experiences implementing the program and interacting with newly-arrived immigrant youth; and 3) students' experiences participating in the program and general perceptions of their lives in the United States.

Qualitative – Content Analysis

We also used a form of qualitative analysis, called content analysis coding (Kyngas, 2020), to review de-identified, consolidated notes from two social workers who conducted individualized support sessions with students.

Sample

Quantitative – Statistical Data

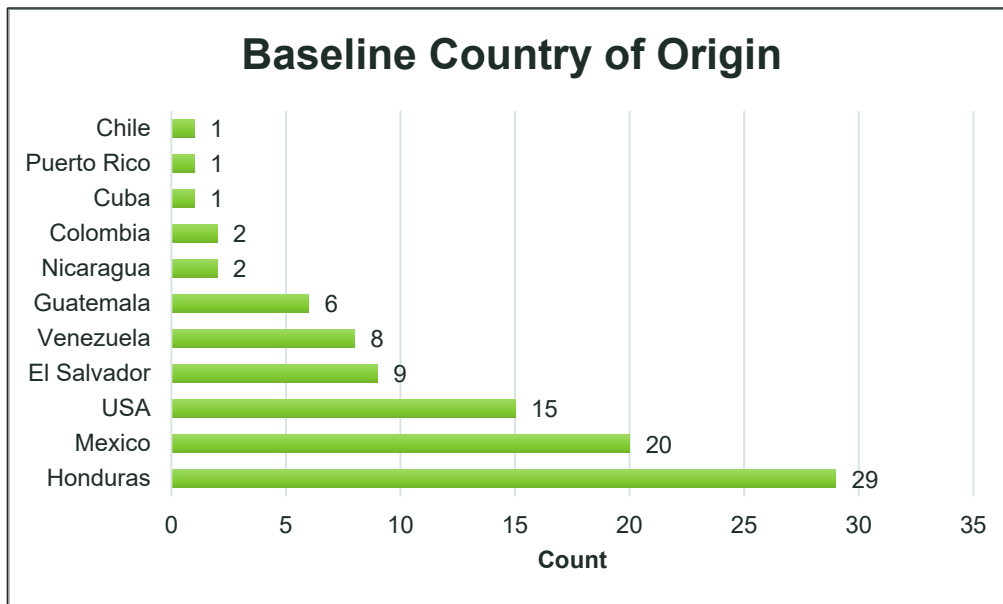
On average, participants at pre-test were 15.04 years old (range=12 to 20), and 53 were male and 41 were female. All participants self-identified as Hispanic/Latinx. As shown in Table 1, a total of 94 individuals participated in the Bienvenido program. Demographically, there was a diverse participant pool, with the majority of participants from Honduras (n=29), followed by Mexico (n=20), the United States (n=15), El Salvador (n=9), Venezuela (n=8), and other countries (n=13). Participants reported an average length of 2.71 total years in the United States, with the majority of participants reporting their length of stay as less than one year

(65%). The majority of participants reported speaking English "not at all" or "a little" (89%). Participants also had varying work experience in construction and agriculture, as 29% of individuals reported they had completed work in these fields (Table 1).

Table 1. *Demographics of participants involved in the Bienvenido program as reported in the Bienvenido pre-test survey instrument*

Participant Demographics	n (Total n=94)	Percentage
Country of Origin		
Honduras	29	31%
Mexico	20	21%
United States	15	16%
El Salvador	9	10%
Venezuela	8	9%
Other	13	14%
Length of Stay in United States		
1-4 mo.	17	18%
5-8 mo.	42	45%
9-11 mo.	2	2%
1-2 yrs.	6	6%
2-5 yrs.	19	20%
5+ yrs.	1	1%
No Response	7	7%
Level of English Proficiency		
Not at all	20	21%
A little	64	68%
Good	5	5%
Very well	3	3%
No response	2	2%
Number of Years Working in Construction/Agriculture		
None	62	66%
<1-4 yrs.	21	22%
5-9 yrs.	3	3%
10+ yrs.	4	4%
No response	4	4%

Figure 1. Participants' country of origin



Among the 94 participants, the Bienvenido program included 39 students from Goshen High School, 20 students from Pierre Moran Middle School (Elkhart), and 35 students from Elkhart High School Freshman Division (see Table 2). Most participants completed the pre- and post-test components, but there was a loss to follow-up for some participants because the post-test was completed close to the end of the school year. As part of the program, 32% of participants also received individualized support sessions from licensed social workers in conjunction with the program curriculum (see Table 3).

Table 2. Sample of participants that participated in the Bienvenido program

School	Program Dates (2022)	# Students	# Completed Pre-tests	# Completed Post-tests	# Completed Follow-up Tests
Goshen High School (A)	Feb. 28 to May 22	19	19	17	15
Goshen High School (B)	Mar. 3 to May 5	20	20	19	15
Pierre Moran Middle School (Elkhart)	Mar. 2 to May 3	20	20	20	19
Elkhart High School Freshman Division (A)	Jan. 18 to Mar. 8	18	18	15	15
Elkhart High School Freshman Division (B)	Mar. 21 to May 23	17	17	17	0
Total n (%)		94	94 (100%)	88 (94%)	64 (68%)

Table 3. Sample of Bienvenido participants that received individualized support sessions

School	Program Dates (2022)	# Students	# Students Received Support Sessions	Received one session	Received two sessions	Received three sessions	Received four sessions
Goshen High School (A)	Feb. 28 to May 22	19	9 (47%)	6	1	1	1
Goshen High School (B)	Mar. 3 to May 5	20	11 (55%)	6	2	3	0
Pierre Moran Middle School (Elkhart)	Mar. 2 to May 3	20	5 (25%)	3	1	1	0
Elkhart High School Freshman Division (A) ¹	Jan. 18 to Mar. 8	18	0 (0%)	0	0	0	0
Elkhart High School Freshman Division (B)	Mar. 21 to May 23	17	5 (29%)	5	0	0	0
Total n (%)		94	30 (32%)	20 (21%)	4 (4%)	5 (5%)	1 (1%)

¹Individualized support sessions were not offered to this group of students because, as a pilot group, NIHHC did not get the extra time necessary from the school for such support sessions to occur within the school day.

Qualitative – Focus Groups & Interviews

In total, we conducted three focus groups and two one-on-one interviews (see Table 4).

Table 4. Sample of participants who participated in the focus groups and interviews

Participants	Focus Groups	Interviews
School Corporation Staff (Administrators)	1	1
Bienvenido Facilitator/Assistant and Social Worker (Administrators)	1	1
Students	1	0
Total	3 Focus Groups	2 Interviews

In Tables 5 and 6, we describe the age and gender of the focus group and interview participants, among both administrators and students, respectively. It is important to note that in the focus groups for administrators, individuals who participated were associated with several

different schools. In the focus group for students, all participants were solely from Goshen High School.

Table 5. Gender, age, and role of individuals who participated in focus groups

Participants	Sample Size	Gender	Age Range	Professional Role
School Corporation Staff (Focus Group #1 with Administrators)	6	6 Female	33-45	English Teachers, English Language & Community Specialist, Academic Advisor/Parent Liaison, Program Facilitator*, Program Assistant*
Bienvenido Facilitator/Assistant and Social Worker (Focus Group #2 with Administrators)	3	2 Female 1 Male	40-55	Program Facilitator*, Program Assistant* Curriculum Developer
Students¹	6	4 Female 2 Male	15-18	Students

* Signifies an individual who participated in more than one focus group.

¹The Academic Advisor/High School Parent Liaison and an English Language & Community Specialist were present at the student focus group.

Table 6. Gender, age, and role of individuals who participated in the interviews

Participants	Sample Size	Gender	Age Range	Professional Role
Administrators	2	2 Female	40-55	Social Worker, ¹ Academic Advisor/Parent Liaison

¹The social worker was one of two social workers responsible for conducting individualized support sessions as part of the Bienvenido program. She also facilitated a session on suicidal thoughts.

Qualitative – Content Analysis

We also reviewed two de-identified, consolidated notes from the two social workers who conducted 47 individualized support sessions with 30 students across one high school, one middle school, and one freshman division high school. The social workers who conducted the sessions have a perspective informed by sessions with participants of varying ages across the school corporation.

Data Collection Procedures

Quantitative

The program facilitators distributed paper surveys to the participants at the beginning of the first session. After introducing the program, establishing expectations, and running an icebreaker activity, they allotted 20 minutes of the session for participants to complete the pre-test survey. During the ninth and final session, participants completed the post-test in the last 20 minutes of class, prior to the graduation ceremony and the distribution of recognitions. Regarding the follow-up, paper surveys were distributed to students approximately three weeks after the post-test at their respective locations (Pierre Moran Middle School, Goshen High School, and Elkhart High School Freshman Division).

Qualitative – Focus Groups & Interviews

Jean Marie Place, PhD, and Liliana Quintero, MBA, led the focus groups and interviews over a series of days from June 8-22, 2022, conducted through the online Zoom platform. Quintero worked with local contacts to determine the dates for data collection. The focus groups and interviews were held mainly online on a scheduled day and time, each conducted in a private space. Prior to starting the focus group or interview, we obtained verbal consent to record the session, assured individuals of confidentiality, and indicated that the focus group or interview would last approximately 45 to 60 minutes.

Qualitative – Content Analysis

As part of the contract with the social workers who conducted individualized support sessions with a selection of students identified as in need of additional education, they were asked to provide written summaries of the sessions, indicating the most common issues they identified among the students. They followed HIPAA guidelines protecting patient information and confidentiality.

Instruments

Quantitative – Statistical Data

One section of the survey instrument (Appendix A) included items addressing multiple different constructs, including self-esteem, social support, perception of mental health, comprehension of mental health terminology, participation in community service or extracurricular activities, and behavior in school. These questions were formatted with a Likert scale with answers ranging from “Strongly disagree,” “Disagree,” “Agree,” and “Strongly agree.”

The survey also had questions from the Patient Health Questionnaire (PHQ-9). The PHQ-9 is a self-administered version of the PRIME-MD instrument for common mental disorders that assesses whether the patient experiences depression (Sun et al., 2020). One study conducted in 2001 found that as PHQ-9 depression severity increased, there was a decrease in patients’ functionality and an increase in symptom-related difficulty and sick days (Sun et al., 2020). The PHQ-9 is deemed a reliable and valid measure of depression severity. Another study in 2020

found that the PHQ-9 demonstrated good reliability, validity, and adaptability for a sample size of 109 patients with major depressive disorder (Kroenke et al., 2001). Though there is a modified set of questions for adolescents, the Bienvenido survey instrument utilized questions from the adult version of the PHQ-9, as the adapted version for teenagers is not research validated (Plemmons, 2019). Further, the sensitivity and specificity of the adult version of the PHQ-9, when utilized in a sample of adolescents, were reported as 89% and 77%, respectively (Plemmons, 2019). These questions used a scale of “No days,” “Several days (less than 6 days),” “More than half of the days (between 7 and 10 days),” and “Almost every day (between 11 and 14 days).”

Finally, the survey included questions from the Youth Risk Behavior Surveillance System (YRBSS), which was developed by the Centers for Disease Control and Prevention (CDC, 2021). The YRBSS evaluates six categories of priority health behaviors, including those that lead to unintentional injuries and violence; sexual behaviors related to unintended pregnancy and sexually transmitted diseases; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity (CDC, 2021). The questions included in the Bienvenido survey instrument measured use of alcohol, tobacco (cigarettes and vaping), and illicit drugs. These questions utilized a scale of “never,” “1 time per month or less,” “2-4 times per month,” “2-3 times per week,” and “4 or more times per week.” The CDC has conducted test-retest reliability studies on previous versions of the questionnaire to ensure that the instrument is valid and reliable.

Quantitative – Open-ended Questions

The survey instrument included three open-ended questions: 1) the top three stressors participants experience; 2) three coping strategies the participants employ to deal with the stressors; and 3) three methods to improve mental health (Appendix A).

Qualitative – Focus Groups & Interviews

The interview guide for the administrators consisted of approximately 26 questions (plus additional prompts) designed to elicit information on experiences implementing the program and interacting with newly arrived immigrant students (Appendix B). The interview guide for the students consisted of approximately 15 questions (plus additional prompts) designed to assess students’ experiences participating in the program and general perceptions of their lives in the United States (Appendix B).

Analysis

Quantitative – Statistical Data

The quantitative statistical analysis was based on the following three questions:

Question 1. What factors predict pre-test scores for depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes?

Question 2. Are there changes across participants in depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes from pre-test to post-test and from pre-test to follow-up?

Question 3. Are there changes in mental and behavioral health indicators among cohorts of participants according to education level (e.g., freshman class and high school students)?

After data collection, data were cleaned by eliminating responses that did not pertain to the question. Quantitative data were analyzed in the statistical software, R version 4.1.0 (2021-05-18). Analyses included descriptive statistics to understand distributions and frequencies of data and multivariate analyses for Question 1, including logistic regression and linear regression (“binomial family” and “Poisson” in R). Multivariate models controlled for age and gender. Univariate tests were used to measure change from pre-test to post-test and follow-up and included chi-square tests for categorical outcomes and t-tests for continuous outcomes. Significance was measured with a maximum alpha of 0.05, and the cut-off for marginally significant findings was a maximum alpha of 0.10.

Total scores were computed for the following measures: PHQ-9, self-esteem, and social support. The PHQ-9 included eight questions from the Patient Health Questionnaire. Self-esteem included the following items: “I feel like I am a person who is just as valuable as everyone else,” “I feel like I have many good qualities,” and “I have a feeling that I don’t have much to be proud of.” Social support included the following items: “In difficult moments, I have a trusted adult I can go to,” “There are people who ask for my help,” “I have someone I can talk to about important decisions in my life,” and “I have people who have the same interests and concerns as I do.” All questions for self-esteem and social support were based on a 4-point Likert scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree).

Quantitative – Open-ended Questions

We thematically analyzed the three open-ended questions about stressors and coping mechanisms. Members of our research team coded each specific response and then combined and quantified these codes into general themes among pre-, post-, and follow-up data, by school. We then compared the themes across time periods. After analyzing the open-ended responses per school, we generated overarching themes across the entire sample by combining

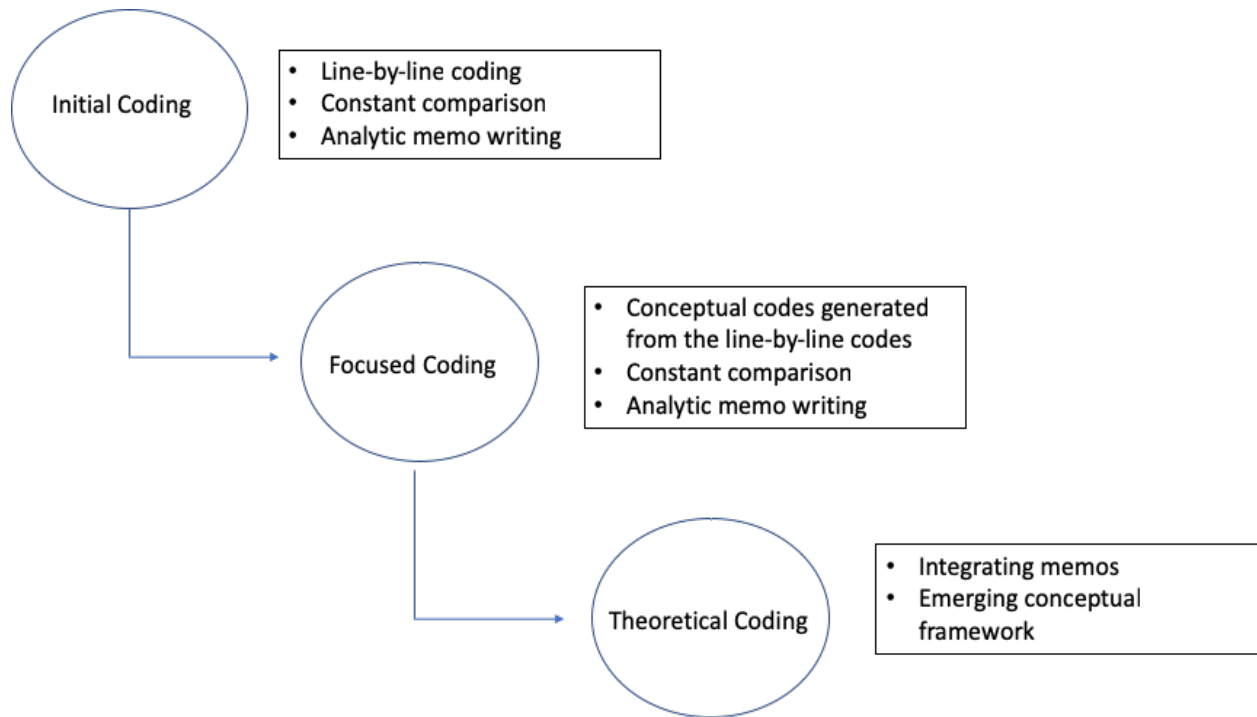
the themes. We created this holistic view of the data on Microsoft Excel. Among all participants, we identified 13 overarching themes for the stressors' participants experience, 13 themes for the coping mechanisms participants employ, and 8 themes for other possible coping mechanisms (Appendices C through K). We provide frequency analysis of the number of participants reporting each theme, across time periods, along with percentages of participants responding based on the sample. We also provide salience analysis of the number of participants reporting each theme, across time periods, along with the order in which these themes are reported. While we initially analyzed the data qualitatively, we ultimately compared and reported the data quantitatively, thus we consider this a quantitative analysis.

Qualitative – Focus Groups and Interviews

Focus group and interviews were recorded with verbal informed consent. They were transcribed in English and uploaded to the qualitative software, NVivo 12. A more detailed account of the data is included in the data section below, however, a brief outline of the steps of the data analysis process is provided here: 1) We divided the transcripts by whether they were conducted with administrators (i.e. school staff, Bienvenido facilitators/assistants, and social workers), or students; 2) We conducted line-by-line analysis. Among administrators, we generated 80 line-by-line codes (Appendix L). Among the students, we generated 28 line-by-line codes (Appendix M); 3) We conducted focused coding. Among administrators, we generated 43 focused codes (Appendix N). Among students, we generated 18 focused codes (Appendix O); 4) We categorized the focused codes; 5) Finally, we looked for overall patterns among the focused codes, which served as a collective statement about the impact of the program and the state of participants in the program. These are called the theoretical codes.

A graphic is included to illustrate the data analysis process (see Figure 2).

Figure 2. *Depiction of the data analysis process of the qualitative data*



Qualitative – Content Analysis

To begin, we read through each set of de-identified, consolidated notes provided by the social workers who conducted the individualized support sessions. Then, we uploaded the notes to NVivo 12 and extracted phrases, sentences, or stories and assigned the data a code. Data with similar content were assigned existing codes, ultimately creating 138 separate line-by-line codes that represented different elements and patterns in the data (Appendix P). Narrative descriptions were then written to summarize and illustrate the content within the notes.

RESULTS

Quantitative – Statistical Data

In Tables 7, 8, and 9, we provide summary statistics of a range of variables for participants across pre-test, post-test, and follow-up time periods. Appendix A provides an example of the survey participants completed.

Table 7. Summary statistics for pre-test measures for all students

Variable	Min	Max	Mean	Median
1. Age in years	12.00	20.00	15.04	15.00
2. Total score on PHQ-9	0.00	23.00	9.67	9.00
3. Self-esteem	5.00	16.00	11.57	11.00
4. Social support	4.00	16.00	12.05	12.00
5. Current and past smoking	1.00	5.00	1.18	1.00
6. Current and past vaping	1.00	5.00	1.27	1.00
7. Current and past alcohol consumption	1.00	5.00	1.42	1.00
8. Current and past illicit drug consumption	1.00	3.00	1.08	1.00
9. Attendance at individualized support sessions	1.00	4.00	1.25	1.00
10. Participation in community service or extracurricular activities	1.00	4.00	1.41	1.00
11. Received disciplinary sanction at school	1.00	4.00	1.38	1.00
12. Frequency of poor mental health during COVID-19 pandemic	1.00	5.00	2.43	2.00
13. Family member lost job during COVID-19 pandemic	1.00	3.00	2.45	2.00
14. Level of English	1.00	4.00	1.90	2.00
15. Years worked in agriculture / construction / manufacturing	0.00	12.00	1.05	0.00
16. Knowledge of adaptation process in U.S.	1.00	4.00	2.66	3.00
17. Knowledge of terms “mental health,” “mental illness,” and “substance use”	1.00	4.00	2.77	3.00
18. Length of time in U.S.	1-4 months	5-10 years		
Variable	Yes/Male		No/Female	
Gender	53		41	
Medical insurance	18		60	
Hispanic/Latinx	94		0	

Table 8. Summary statistics for post-test measures

Variable	Min	Max	Mean	Median
1. Age in years	12.00	20.00	15.03	15.00
2. Total score on PHQ-9	0.00	24.00	8.47	7.00
3. Self-esteem	4.00	16.00	11.92	12.00
4. Social support	6.00	16.00	12.08	12.00
5. Current and past smoking	1.00	3.00	1.15	1.00
6. Current and past vaping	1.00	3.00	1.16	1.00
7. Current and past alcohol consumption	1.00	3.00	1.10	0.00
8. Current and past illicit drug consumption	1.00	3.00	1.04	1.00
9. Attendance at individualized support sessions	1.00	4.00	1.54	1.00
10. Participation in community service or extracurricular activities	1.00	4.00	1.48	1.00
11. Received disciplinary sanction at school	1.00	4.00	1.42	1.00
12. Frequency of poor mental health during COVID-19 pandemic	1.00	4.00	2.25	2.00
13. Family member lost job during COVID-19 pandemic	1.00	3.00	2.50	3.00
14. Level of English	1.00	4.00	1.91	2.00
15. Years worked in agriculture / construction / manufacturing	0.00	12.00	1.06	0.00
16. Knowledge of adaptation process in U.S.	1.00	4.00	2.82	3.00
17. Knowledge of terms “mental health,” “mental illness,” and “substance use”	1.00	4.00	3.12	3.00
18. Length of time in U.S.	1-4 months	10+ years		

Variable	Yes/Male	No/Female
Gender	48	40
Medical insurance	22	53
Hispanic/Latinx	88	0

Table 9. Summary statistics for follow-up measures

Variable	Min	Max	Mean	Median
1. Age in years	12.00	20.00	15.22	15.00
2. Total score on PHQ-9	0.00	23.00	7.42	7.00
3. Self-esteem	6.00	16.00	12.40	12.00
4. Social support	4.00	16.00	12.17	12.00
5. Current and past smoking	1.00	4.00	1.29	1.00
6. Current and past vaping	1.00	4.00	1.29	1.00
7. Current and past alcohol consumption	1.00	4.00	1.30	1.00
8. Current and past illicit drug consumption	1.00	4.00	1.10	1.00
9. Attendance at individualized support sessions	1.00	4.00	1.38	1.00
10. Participation in community service or extracurricular activities	1.00	4.00	1.48	1.00
11. Received disciplinary sanction at school	1.00	4.00	1.41	1.00
12. Frequency of poor mental health during COVID-19 pandemic	1.00	5.00	2.36	2.00
13. Family member lost job during COVID-19 pandemic	1.00	3.00	2.57	3.00
14. Level of English	1.00	4.00	2.02	2.00
15. Years worked in agriculture / construction / manufacturing	0.00	12.00	0.79	0.00
16. Knowledge of adaptation process in U.S.	1.00	4.00	3.18	3.00
17. Knowledge of terms “mental health,” “mental illness,” and “substance use”	1.00	4.00	3.16	3.00
18. Length of time in U.S.	1-4 months	5-10 years		

Variable	Yes/Male	No/Female
Gender	37	27
Medical insurance	17	42
Hispanic/Latinx	64	0

The multivariate analyses were made across pre-test, post-test, and follow-up time periods for all students and specific cohorts based on three research questions: 1) *What factors predict pre-test scores for depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes?*; 2) *Are there changes across students in depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes from pre-test to post-test and from pre-test to follow-up?*; and 3) *Are there changes in mental and behavioral health indicators among cohorts of participants according to education level (e.g., freshman class and high school students)?*.

Question 1. What factors predict pre-test scores for depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes?

Pre-test

Findings from the multivariate analyses at pre-test indicated that participants who had lower levels of self-esteem had higher levels of depressive symptoms. Participants who reported lower levels of social support also had higher levels of depressive symptoms. Having social support, however, was associated with higher levels of self-esteem. Finally, depressive symptoms were higher if a participant's parent or other adult in the family lost their job during the COVID-19 pandemic.

A more detailed analysis of the main results follows. At pre-test, lower scores on total self-esteem (Variable 3) were significantly associated with higher scores on the PHQ-9 (Variable 2) (coef. = -0.05, $p < 0.0001$), controlling for the effects of age and gender, of which gender was also significant with girls being more depressed than boys (coef. = 0.187, $p = 0.001$). Lower scores on social support (Variable 4) were also significantly and inversely related to depressive symptoms (Variable 2) (coef. = -0.03, $p < 0.001$), controlling for age and gender, which were also significant (coef. = -0.01, $p < 0.001$ and coef. = 0.21, $p < 0.001$, respectively). Social support (Variable 4) was found to be a protective factor for self-esteem (Variable 3), with higher levels of social support significantly and positively associated with self-esteem in baseline participants (coef. = 0.04, $p = 0.001$), controlling for the effects of age and gender (coef. = -0.007, $p = 0.76$ and coef. = -0.04, $p = 0.49$, respectively).

None of the other variable combinations was significant at pre-test.

Question 2. Are there changes across students in depression, self-esteem, knowledge of mental health terminology, social support, substance use, community service or extracurricular activities, behavior in school, participation in individualized support sessions, and knowledge of U.S. adaptation processes from pre-test to post-test and from pre-test to follow-up?

Pre-test to Post-test

At post-test, more participants reported having knowledge about mental health, mental illness, and substance use. They also reported greater participation in individualized support sessions, which were offered by NIHHC during the Bienvenido program, from pre-test to post-test.

A more detailed analysis of the main results follows. There was a 7% increase from pre-test to post-test in knowledge about mental health, which was significant according to a Chi-Square test (Variable 17, “I know the meaning of the terms ‘mental health’ and ‘mental illness’ and ‘substance use’ and I can explain them to someone else”; $X^2=9.42$, $p=0.024$). Participants also reported a 30% increase in participation in individualized support sessions from pre-test to post-test, which was also significant according to a Chi-Square test (Variable 9, $X^2=11.53$, $p=0.01$).

Figure 3. *There was a 7% increase in average mental health knowledge from pre-test to post-test across all schools.*

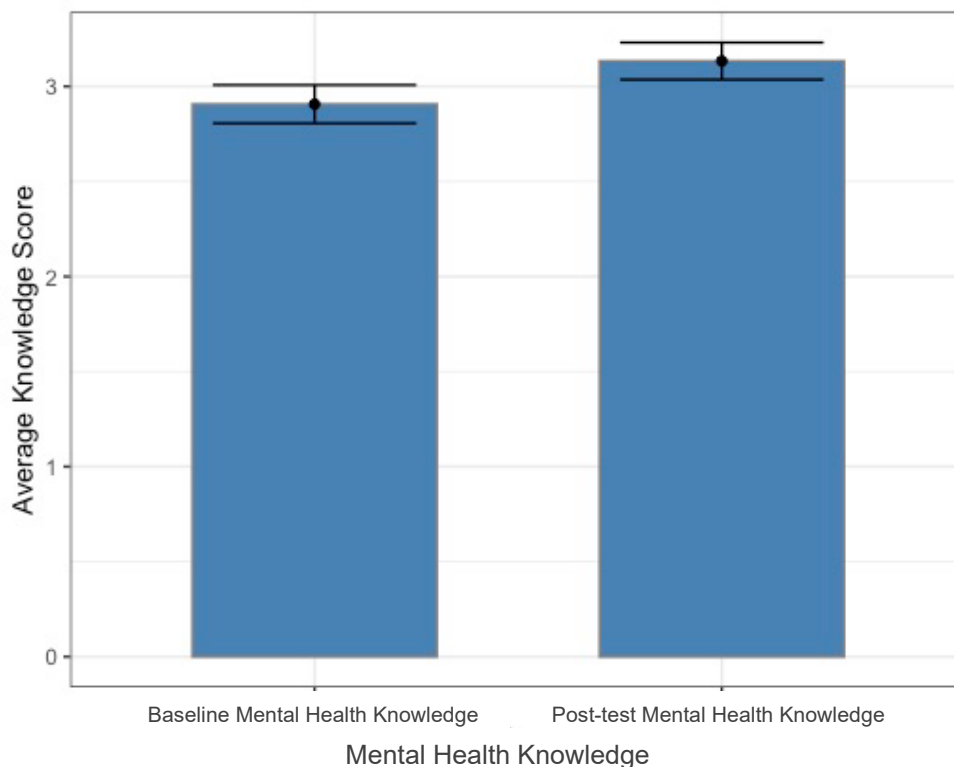
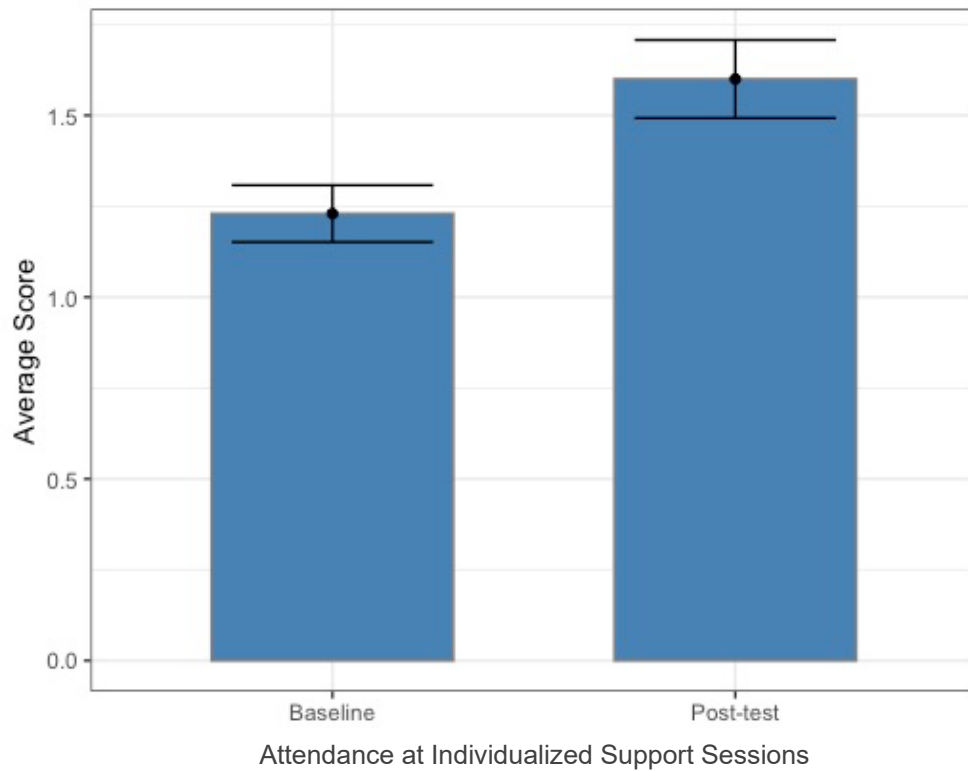


Figure 4. *There was a 30% increase in participation in individualized support sessions from pre-test to post-test across all schools.*

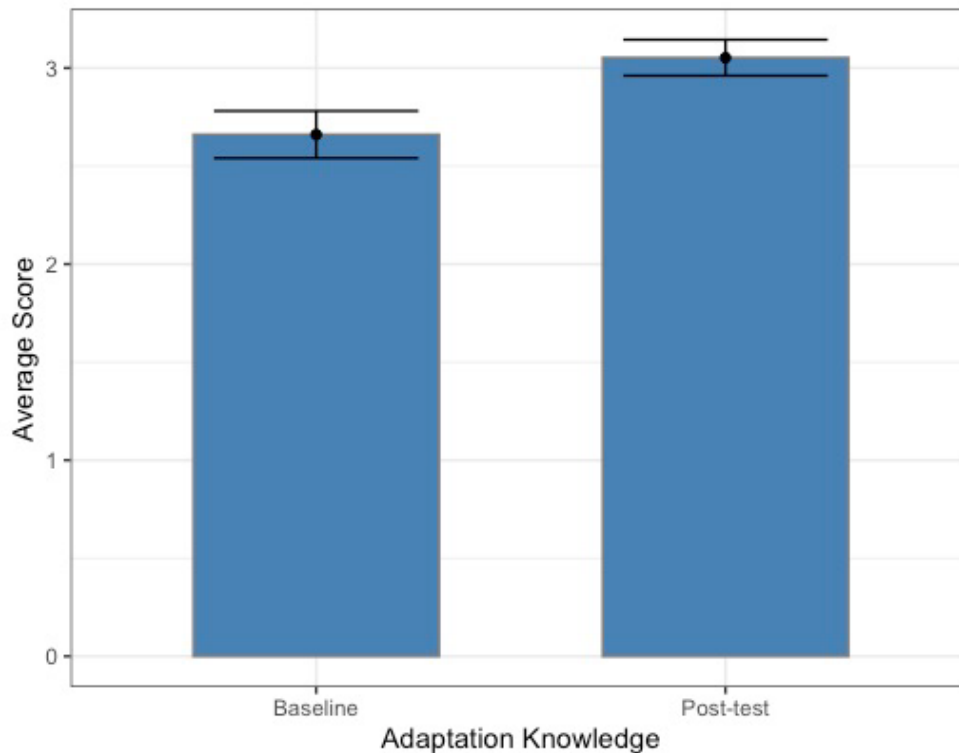


Pre-test to Follow-up

At follow-up, participants reported an increase in knowledge regarding the adaptation process in the United States.

A more detailed analysis of the main results follows. There was a 15% increase in adaptation knowledge from pre-test to follow-up (Variable 16, “I know enough about the adaptation process of living in the United States”; $\chi^2=8.80, p=0.03$).

Figure 5. There was a 15% increase in adaptation knowledge from pre-test to follow-up across all schools.



Question 3. Are there changes in mental and behavioral health indicators among cohorts of participants according to education level (e.g., freshman class and high school students)?

Goshen High School Students Pre-test to Post-test

More Goshen high school students reported an increase in self-esteem at post-test and a slight increase in knowledge of mental health, mental illness, and substance use.

A more detailed analysis of the main results follows. There were 30 Goshen high school students who completed both pre-test and post-test surveys. A t-test found a significant increase in self-esteem at post-test (10%; $t=2.17$, $p=0.03$), and a marginally significant increase in knowledge of mental health terminology (7%; $X^2=6.58$, $p=0.09$).

Figure 6. There was a 10% increase in self-esteem from pre-test to post-test in Goshen High School students.

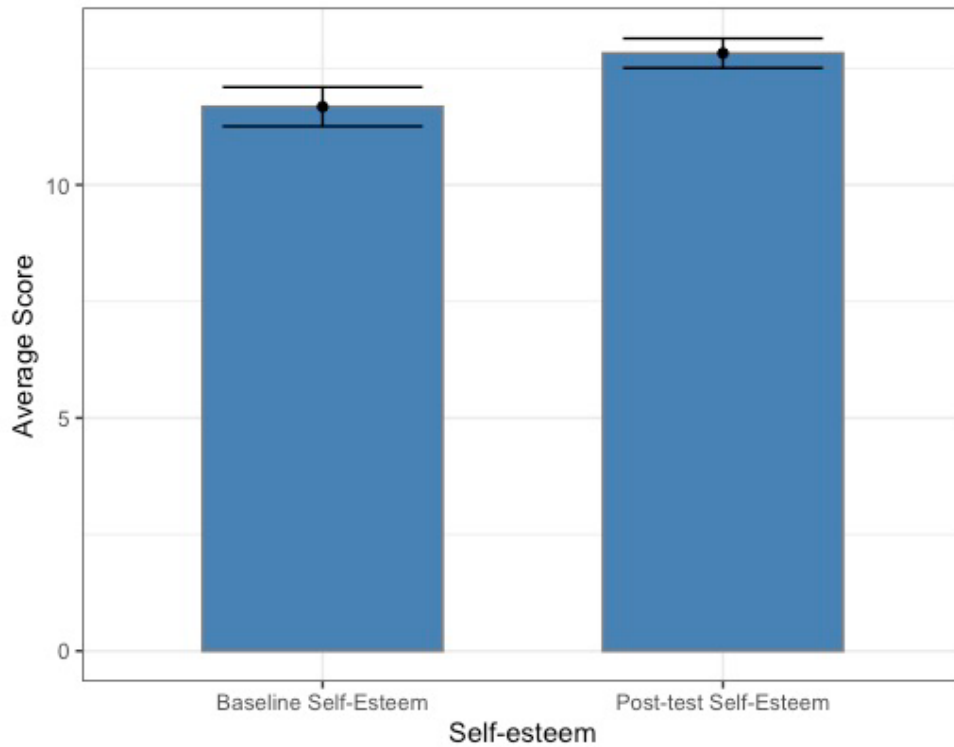
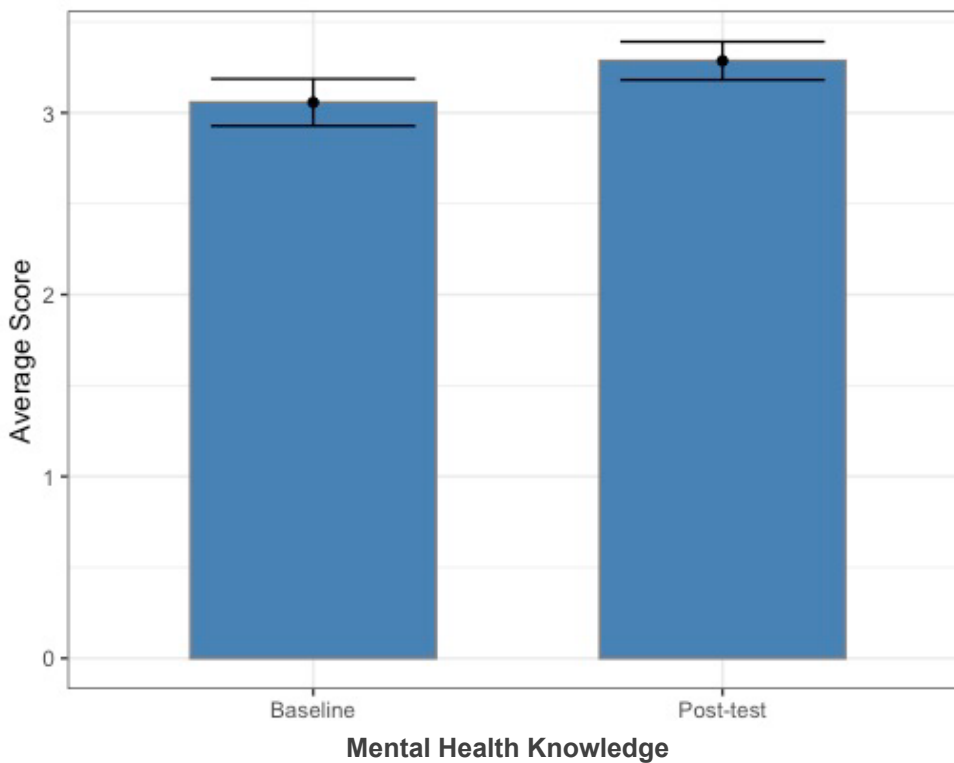


Figure 7. There was a 7% increase in knowledge of mental health terminology from pre-test to post-test in Goshen High School students.



Goshen High School Students Pre-test to Follow-up

More Goshen High School students reported a decrease in depressive symptoms from pre-test to follow-up, and an increase in self-esteem from baseline to follow-up. They also reported a slight increase in knowledge about the adaptation process in the United States from pre-test to follow-up.

A more detailed analysis of the main results follows. There were 30 Goshen High School students who completed both pre-test and follow-up surveys. There was an 18% decrease in depressive symptoms from baseline to follow-up, which was significant according to a t-test ($t=-2.62$, $p=0.01$). There was also an 11% increase in self-esteem from baseline to follow-up, which was statistically significant ($t=2.26$, $p=0.03$). Finally, there was a 19% increase in adaptation knowledge from baseline to follow-up, which was marginally significant ($X^2=6.92$, $p=0.07$).

Figure 8. *There was an 18% decrease in depressive symptoms from pre-test to follow-up in Goshen High School students.*

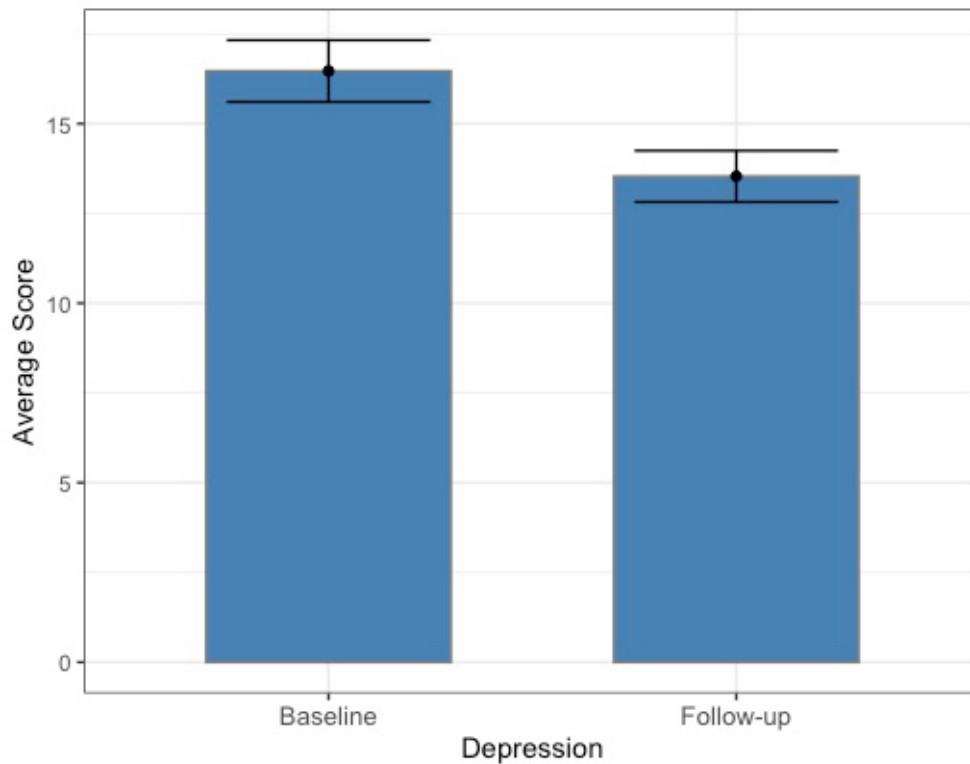


Figure 9. There was an 11% increase in self-esteem scores from pre-test to follow-up in Goshen High School students.

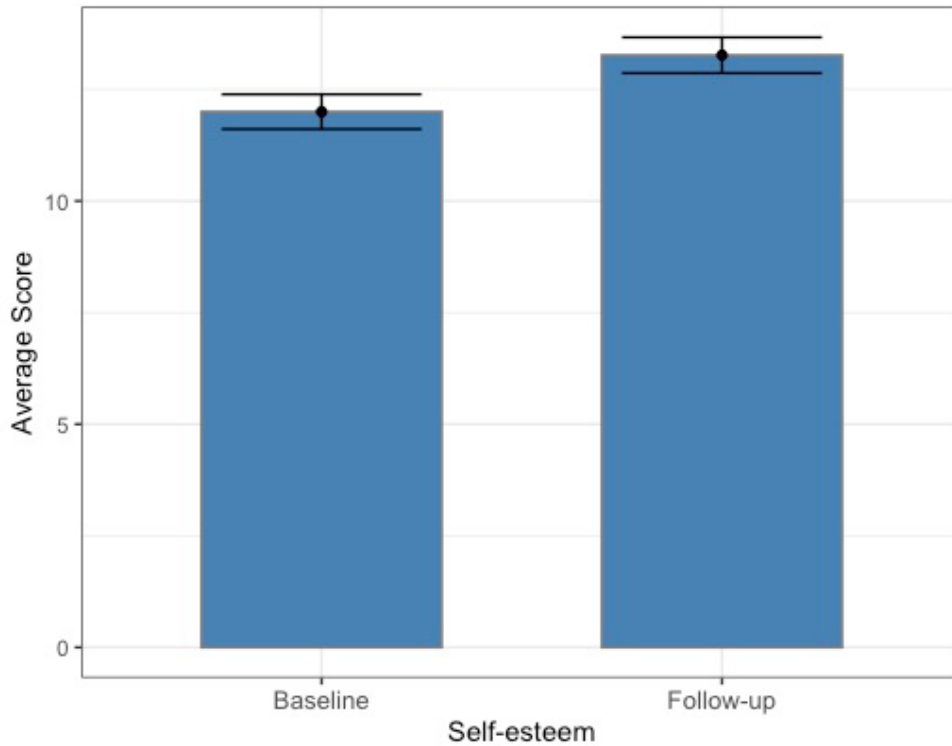
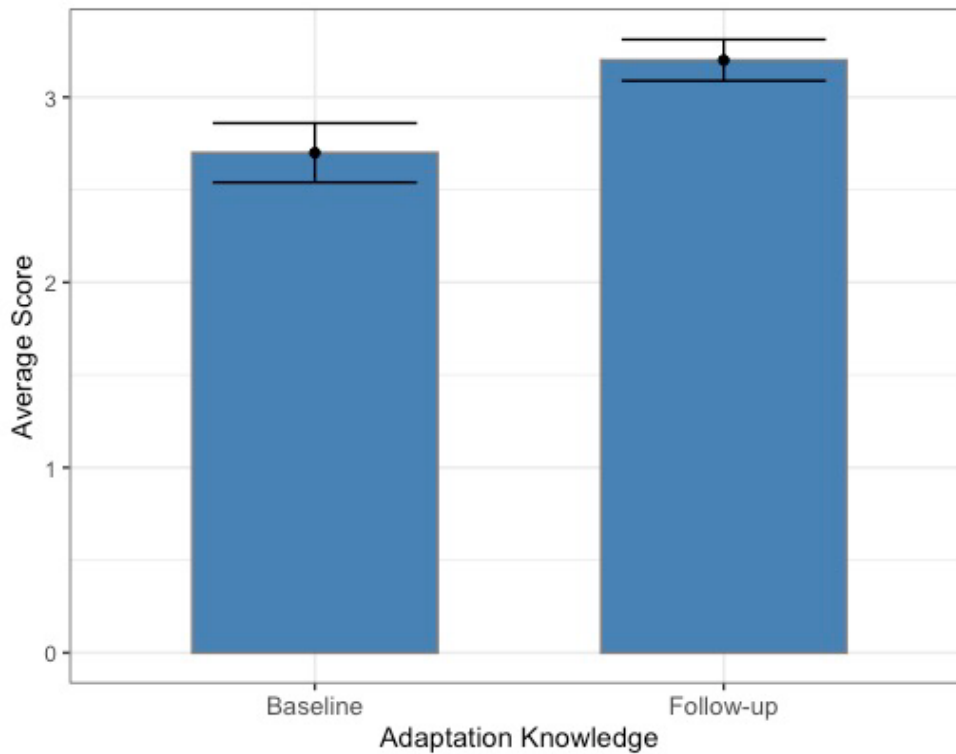


Figure 10. There was a 19% increase in adaptation knowledge from pre-test to follow-up in Goshen High School students.

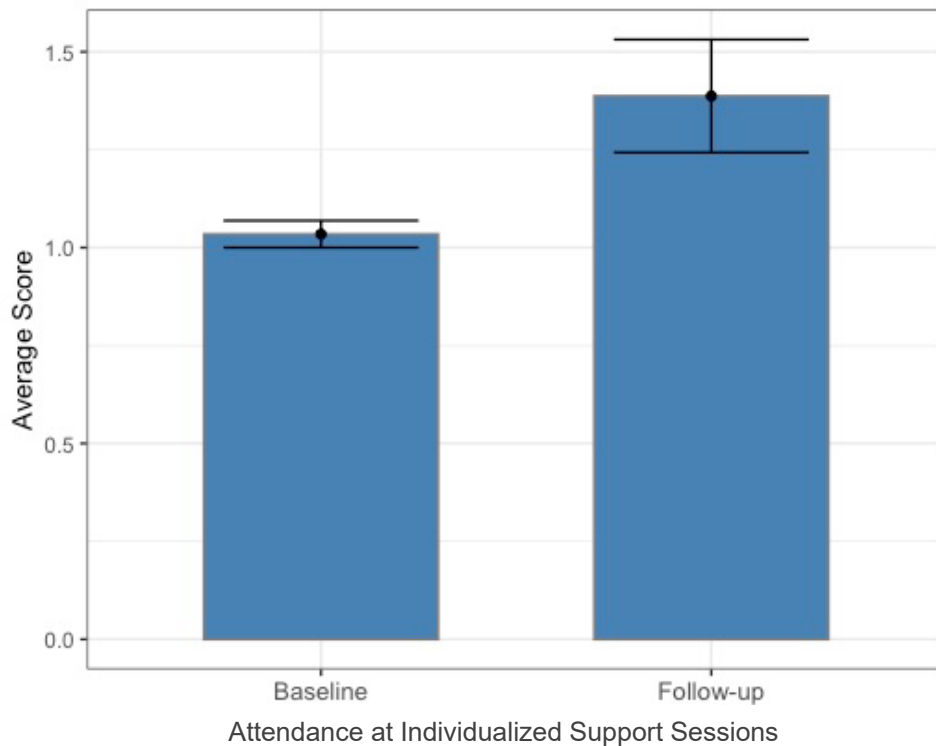


Freshman Students Pre-test to Post-test

Freshman students reported an increase in participation in individualized support sessions from baseline to follow-up.

A more detailed analysis of the main results follows. Thirty-one students from Elkhart High School Freshman Division completed the pre-test and post-test surveys. There was a 34% increase in attendance at individualized support sessions from pre-test to post-test, which was significant according to a chi-square test ($X^2=6.00$, $p=0.05$).

Figure 11. *There was a 34% increase in attendance at individualized support sessions from pre-test to post-test in freshman students.*



Quantitative – Open-ended Questions

Frequency Analysis

Responses to the open-ended questions were reported by participants on the pre-test, post-test, and follow-up test. Each participant was invited to write up to three responses for each of the three open-ended questions: 1) Question B: *List 3 stressors*, 2) Question C: *List 3 things you can do to cope when you begin feeling stressed*, and 3) Question F: *List 3 things you can do to improve your mental health*. Responses were collected for each question at each time period and then classified into 13 categories for Questions B and C, and 8 categories for Question F. The categories of responses for each question are listed below in each graph (Figures 15-17),

which show the frequency of responses at each time period. Thus, “n,” as referenced in the results, corresponds to the total number of responses.

Question B. List 3 Stressors.

For Question B (*List 3 stressors*), 251 responses were collected for the pre-test, 200 for the post-test, and 226 for the follow-up test, totaling 677 responses. As shown in Figure 15, the identified stressors were diverse. By far, the most common stressor was problems with education 28% (n=188), whether that be unfinished homework, taking exams, or receiving poor grades. Of note, the prevalence of this stressor remained consistent, as 27% (n=69) of responses were related to problems with education in the pre-test, 28% (n=55) in the post-test, and 28% (n=64) in the follow-up test.

We hypothesized that problems with education would be correlated with participants' level of English. However, while some participants expressed struggling with English, their language skills improved throughout the program. In fact, at the beginning of the program, 8% (n=21) of responses were related to problems with English, but at the post-test period, only 5% (n=10) of responses involved problems with English. This language acquisition was still strong in the follow-up period, as just 3% (n=7) of responses were related to problems with English. Thus, we can infer that problems with education may be more related to struggles with American education methodologies. For example, in Latin American countries, students are accustomed to completing tests on paper, but they must complete most work on the computer in the United States. Students may have also experienced more individualized support from homeroom teachers in their home countries, as well as after-school or weekend reinforcement sessions if needed. In the United States, however, especially in large schools such as those where participants were located, this kind of individualized attention is minimal or absent.

The next most common stressor was problems with loud noises 17% (n=112), as participants felt overwhelmed in crowded, noisy, and enclosed environments, which could possibly be an indicator of post-traumatic stress disorder-type symptoms related to their immigration journeys. As a result of their experiences, these participants may be more sensitive to people yelling at them, yelling in general, kids crying, others calling their name repeatedly, or others making repeated statements. Of note, the prevalence of this stressor significantly decreased throughout the pre-test 22% (n=54), post-test 16% (n=32), and follow-up 12% (n=26) periods. The prevalence of this stressor may have decreased over time due to participants becoming more accustomed to American culture since arriving in the United States. For example, the level of noise in schools is very loud during transitions between classes and particularly during lunch, yet students are forced to find ways to tolerate these environments. Students are not allowed to go outside (e.g., to a playground) for lunch or during their free periods, which would afford them a break from the noise. Given that there is not much students can do to avoid such environments, they may have found ways to adapt to them.

Many participants also expressed problems with reaching goals. The prevalence of this stressor remained relatively consistent between the pre-test 7% (n=18), post-test 9% (n=18), and follow-up 9% (n=21) periods. In regard to reaching goals, participants expressed feeling bored, lack of control, having too much responsibility, and losing at something, which could possibly be an indicator of certain gaps in acculturation, homesickness, or disorientation as new immigrants. While one of the program sessions involved helping participants work on setting goals and a specific plan for achieving good mental health, involving a life skills coach to work one-on-one with students to define and reach their goals may have greater impact. Furthermore, many of the stresses expressed by participants with regards to reaching goals were associated with education. Thus, direct involvement with the school is necessary to overcome this stressor.

Another stressor expressed by the students was feeling isolated. Problems with isolation decreased very slightly between the pre-test 8% (n=20) and post-test 7% (n=14), but then increased in the follow-up period 11% (n=25), underlining the possible social support gained during participation in the program. During the program, students connected with peers in the program, many for the first time, while also developing positive relationships with program facilitators and social workers. This social support was significantly reduced when the program ended, thus impacting problems with isolation in the follow-up period. In addition, this period was toward the end of the school year, and for many participants, their only social circle was in school. Thus, the proximity of the school year ending may be associated with isolation, as well.

Some participants reported struggles with their social circles or interpersonal relationships, perceiving others as annoying or rude or citing issues with girlfriends/boyfriends. The prevalence of this stressor remained consistent from pre-test at 7% (n=17) to post-test at 7% (n=13). Problems with social circles increased slightly in the follow-up, as 8% (n=19) of responses were related to this stressor in the follow-up period. This increase could again be associated with a drop in social support after the program ended.

Individuals reported issues with emotions, such as overthinking and self-esteem. As the program intended, these mental health problems varied over time. This stressor increased between the pre-test and post-test. At the pre-test, 6% (n=16) of responses were associated with overthinking and self-esteem, which increased to 8% (n=15) at the post-test. This stressor decreased to 4% (n=10) in the follow-up test. Some participants expressed struggling with family. Interestingly, the prevalence of this stressor increased from 2% (n=4) in the pre-test to 6% (n=12) in the post-test, and then decreased to 4% (n=8) in the follow-up test. This decrease may be due to the individuals' newfound self-awareness of their emotional state.

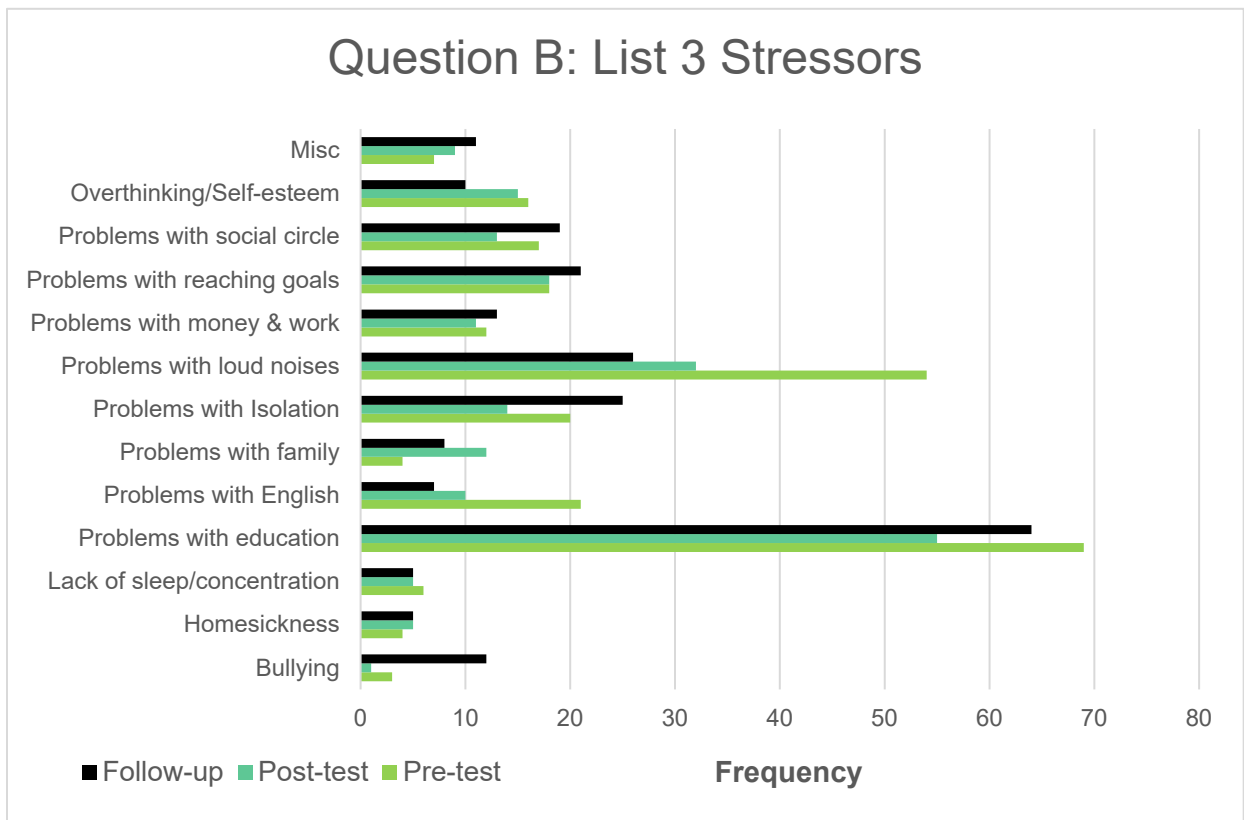
Stressors concerning employment and economic status were also reported by participants, who cited problems with money and work. Problems with money and work were constant throughout the time period, as 5% (n=12) of responses were related to this stressor in the pre-test, 6%

(n=11) in the post-test, and 6% (n=13) in the follow-up test. This problem was prevalent mainly at the high school level, where many of the students were both full-time students and working full time (3rd shift) in local factories. They expressed several reasons for working full time, including a desire to be independent from their guardians, a request from their guardians to begin bringing money home, a desire to support their families in their home countries, and/or feeling responsible for sending money home.

Finally, other stressors included problems with lack of sleep, lack of concentration, weather, faith, homesickness, and bullying. Bullying, in particular, showed a significant increase, from 1% (n=3) in the pre-test to 5% (n=12) in the follow-up. This could be a logical result of students' knowledge and awareness gained during the program. Students may have been victims of bullying, but may have normalized the situation until they understood the concept and increased their self-esteem and use of protection strategies against it.

In sum, participants experienced problems with education as the most frequent stressor, followed by problems with loud noises. Problems related to education, reaching goals, and money and work remained consistent stressors throughout the pre, post, and follow-up periods. Participants experienced significant consecutive decreases through the three time periods in their stress linked to loud noises and English language. From post-test to follow-up, participants experienced an increase in isolation and problems with their social circle, while they experienced a decrease in problems with emotions and with family during the same period.

Figure 12. Question B: List 3 stressors.



Question C. List 3 Things You Can Do to Cope When You Begin Feeling Stressed.

For Question C (*List 3 things you can do to cope when you begin feeling stressed*), 257 responses were collected for the pre-test, 206 for the post-test, and 223 for the follow-up test, totaling 686 responses. Figure 16 displays common coping mechanisms utilized by participants. Looking at the average frequency of each coping mechanism, and checking correlations with the answers given by participants, we can observe how three coping mechanisms directly respond to the top stressor identified in Question B: Problems with education. The most common way to relieve this stressor was to use relaxation techniques (also the most common coping mechanism overall), followed by self-improvement, and lastly, indulging in hobbies. These mechanisms likely helped participants take a break from all of the stress related to daily academic activities.

The use of relaxation techniques refers to deep breathing, meditation, taking longer showers, or spending time with pets. This manner of coping increased from 16% (n=40) at pre-test to 26% (n=54) at post-test. At the follow-up, it decreased to 15% (n=34).

Self-improvement refers to activities such as studying, improving lifestyle, thinking positively, and changing attitude toward and perspective on life. Self-improvement increased throughout all three periods, from 11% (n=28) at pre-test to 14% (n=29) at post-test, and to 16% (n=35) at follow-up.

Indulging in hobbies refers to activities such as reading, drawing, writing poems, or doing enjoyable things. Indulging in hobbies decreased in frequency throughout all three periods, from 6% (n=16) at pre-test to 4% (n=8) at post-test, and to 3% (n=7) at follow-up.

It is encouraging to see how participants reported a wide variety of other coping mechanisms learned from the Bienvenido program in the post-test and follow-up test. This reduced the frequency of the more common coping mechanisms, such as indulging in hobbies, for these time periods.

We can also observe how three of these other coping mechanisms directly respond to the second most frequent stressor identified in Question B: Problems with loud noises. The most common way to relieve this stressor was to listen to music, followed by avoidance or distraction techniques, and finally, going out. These coping mechanisms reflect ways that participants removed themselves from crowded, noisy, and enclosed environments. Thus, in avoiding a common trigger of post-traumatic stress disorder, the mechanisms may have helped participants deal with possible trauma experienced during their immigration journeys.

In the pre-test, 13% (n=33) of responses involved listening to music. In the post-test, the frequency of listening to music was reduced to 10% (n=20), and in the follow-up, it increased to 12% (n=26). Given the strength and consistency of listening to music as a coping mechanism, schools might consider how incorporating music during the academic day could have a positive impact.

The use of avoidance or distraction techniques refers to doing nothing, doing something enjoyable, or avoiding people/problems that cause stress. This manner of coping remained consistent throughout the three periods, from 9% (n=23) at pre-test to 8% (n=16) at post-test, and to 9% (n=20) at follow-up. This trend is positive if we compare this result in parallel with the increase in confiding in trustworthy individuals (see below).

Going out is another coping technique, which includes going out in general, taking walks, or just traveling. This manner of coping increased from 5% (n=12) at pre-test to 8% (n=18) at follow-up. This is a positive sign of getting comfortable in the new environment in which participants were living. In addition, the weather at follow-up (closer to summer) invited them to go outside.

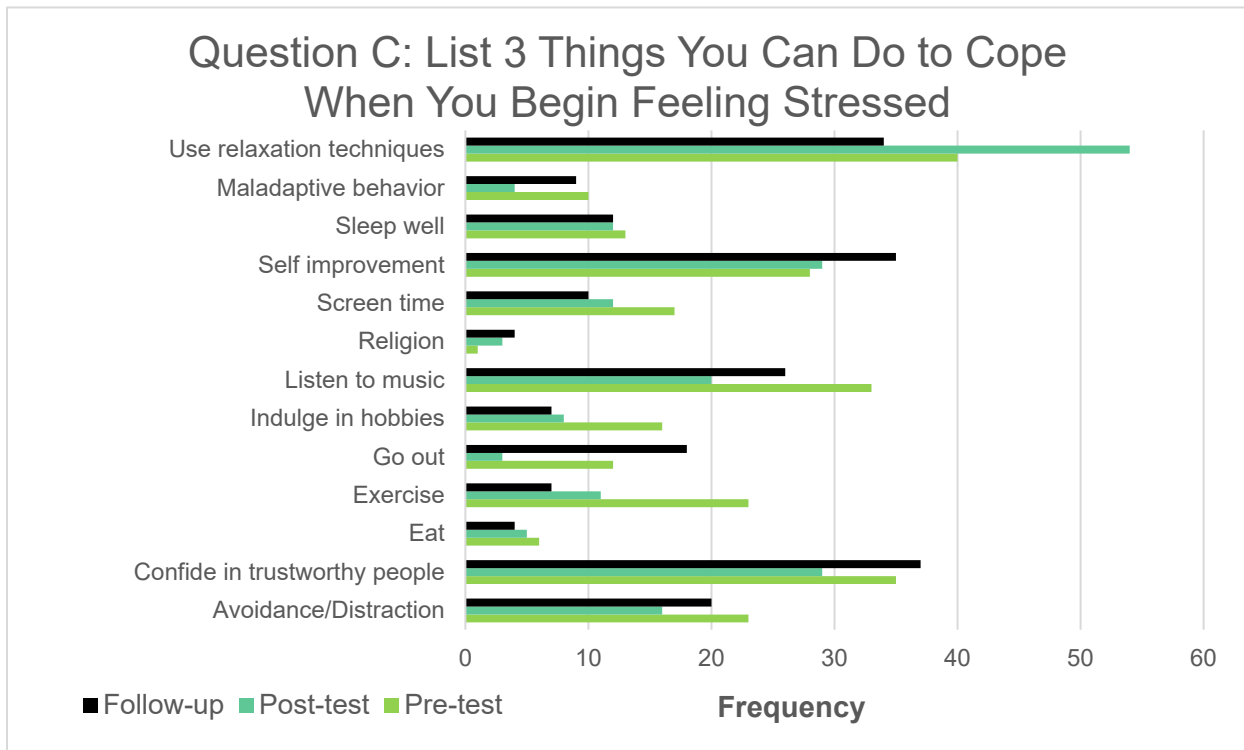
Although weather was not mentioned by participants, studies demonstrate a direct relationship between mental health and weather.

Of note, we identified a group of individuals who favored spending time with others and confiding in trustworthy individuals, while other participants isolated themselves and followed maladaptive behaviors. Regarding confiding in trustworthy people, participants reported socializing more, talking to friends and family, and even visiting a mental health professional. Regarding maladaptive behaviors, participants reported isolating themselves, keeping quiet, doing whatever people say, starting to cut/scratch themselves, and even using medication. As the program went on, however, the frequency of responses related to isolation and/or adopting any of the maladaptive behaviors decreased from 4% (n=10) in the pre-test to 2% (n=4) in the post-test. In the follow-up, it increased to 4% (n=9). This increase in the follow-up test, when the sessions are over, suggests the importance of offering follow-up sessions to reinforce the strategies learned that will prevent participants from turning to maladaptive behaviors. Confiding in others became a more prevalent coping mechanism between the pre-test and follow-up test. In the pre-test, 14% (n=35) of responses were related to confiding in others, 14% (n=29) in the post-test, and 17% (n=37) in the follow-up test. This increase in frequency is a very encouraging result of the program.

Another prevalent way to decrease stress was related to screen time, specifically, being connected to social media, playing video games, or watching TV. Responses related to screen time decreased throughout the three periods, from 7% (n=17) in the pre-test to 6% (n=12) in the post-test, and to 4% (n=10) in the follow-up test. This trend can also be observed with other coping mechanisms, such as doing exercise and sleeping well.

Some participants preferred to take care of themselves by eating healthy, resting/sleeping well, or practicing religion. The prevalence of such activities combined increased from 7% (n=20) at pre-test to 9% (n=20) at post-test and 9% (n=20) at follow-up, although they remained relatively common. Related to taking care of their health, another identified activity included physical activity or playing a sport to relieve stress. Exercise was initially considered a part of self-care; however, its frequency required its own categorization. Exercising decreased throughout the three periods, from 9% (n=23) in the pre-test to 5% (n=11) in the post-test, and to 3% (n=7) in the follow-up test. This decrease may be due to school sports ending at the program's completion for some groups. Most of the Bienvenido classes started in mid spring and ended by the end of the school year. As spring sports seasons ended, opportunities to play sports would have decreased, as school-sponsored sports are unavailable during the summer, and individuals would need to seek out sports on their own in a less structured environment or through paid activities.

Figure 13. Question C: List 3 things you can do to cope when you begin feeling stressed.



Question F. List 3 Things You Can Do to Improve Your Mental Health.

For Question F (*List 3 things you can do to improve your mental health*), 248 responses were collected for the pre-test, 186 for the post-test, and 208 for the follow-up test, totaling 642 responses. Figure 17 shows the common techniques to improve mental health recorded by participants. These reflect the strategies for good mental health and acculturation that students learned during the program. Confiding in trustworthy people, self-improvement, and self-care were the most frequently listed ways to improve mental health, followed by participation in enjoyable activities and visiting a mental health professional.

Confiding in trustworthy people, particularly friends and family, had one of the highest frequencies and remained relatively consistent, from 22% (n=54) at pre-test to 22% (n=41) at post-test to 21% (n=43) at follow-up. This suggests that participants put more time towards talking about their issues with others who they identified as trustworthy people. Identifying sources of support, whether individuals or organizations, was a key strategy students learned to improve mental health. In fact, participants clearly became more comfortable with discussing their mental health with other sources, as well, as exhibited in the increase in visiting a mental health professional, from 8% (n=20) in the pre-test to 13% (n=24) in the post-test to 11% (n=22) in the follow-up, which created the need for its own categorization. The slight decrease from post-test to follow-up is to be expected, given that students had regular access to mental health professionals during the program, but had to seek services on their own after the program

ended. The overall increase speaks to program's impact in overcoming the taboo many participants felt at the beginning of the program in seeking mental health services.

Self-improvement was also one of the most frequently listed themes, and it increased from 21% (n=52) at the pre-test to 26% (n=49) at the post-test. Many participants stated that changing their thinking patterns and developing a positive attitude towards life would improve their mental health. This theme was introduced early on in the program and revisited frequently during sessions. Students learned to identify positive qualities in themselves, as well as their needs in building a new life. In addition, they learned new approaches to managing their circumstances, including goal setting and planning. Students also explored how to handle negative emotions, such as anger, and strategies for acknowledging their feelings and reorienting their attitude to respond to them in a healthy way. Specifically, expressing emotion and understanding communication styles was another strategy students learned. While not frequently listed, it remained consistent, from 2% (n=6) at pre-test to 2% (n=4) at post-test, and 2% (n=5) at follow-up.

Participants recognized that changing their habits, including practicing religion, exercising, sleeping, and eating well, could help them improve their mental health. Responses regarding self-care were consistently high, from 22% (n=55) at pre-test to 15% (n=27) at post-test, and 20% (n=41). The importance of physical health was the focus of one of the sessions, and students explored how it can impact mental health. It is noteworthy that practicing religion is an identified strategy for students. It is vital to address any emphasis on faith to make the program more culturally competent, as religion can be a large part of Hispanic/Latinx culture and is also especially linked to family.

The importance of family, community integration, and general participation in activities was also a theme discussed during the program for improving mental health. Students worked to identify realistic and enjoyable activities that could help them. These are reflected in the activities listed, including going out, listening to music, spending screen time, and participating in hobbies like reading and drawing. On average, participation in enjoyable activities remained consistent at 15% (n=37) in the pre-test, 11% (n=21) in the post-test, and 16% (n=34) in the follow-up.

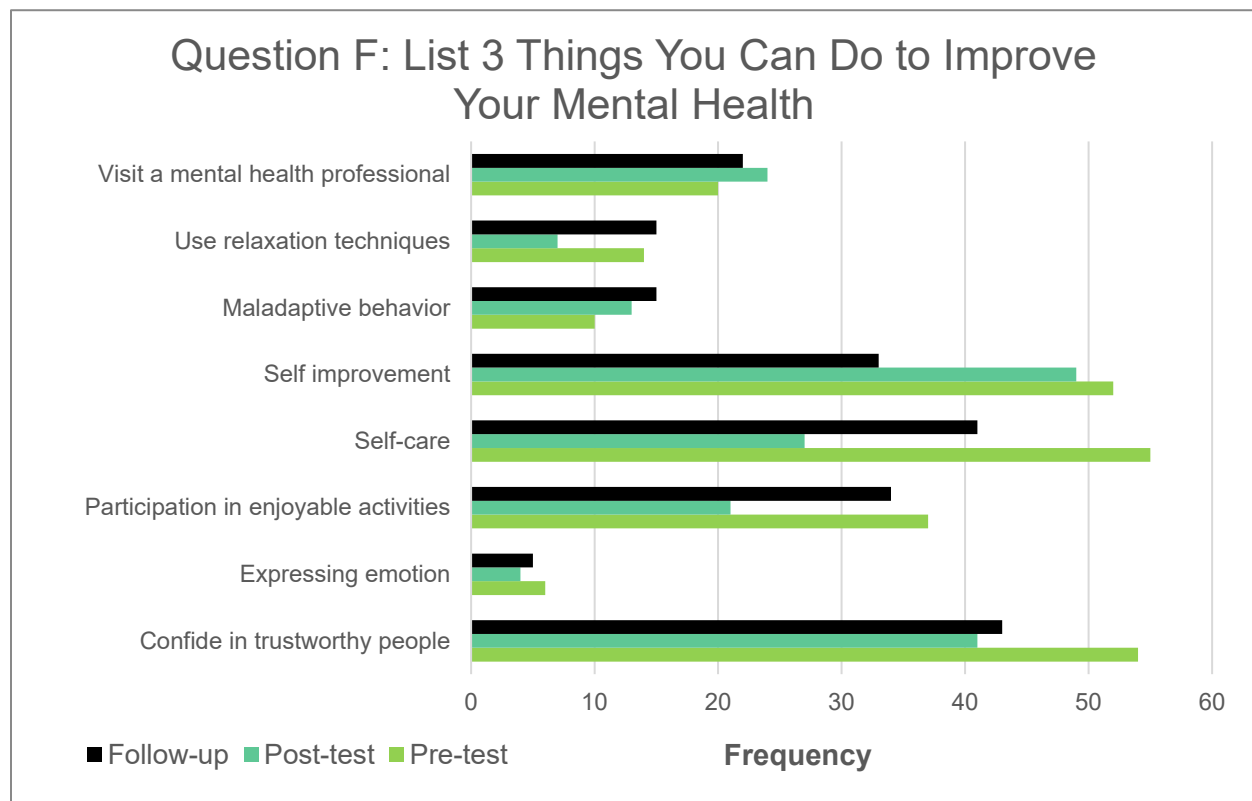
Relaxation techniques were demonstrated during the program, and participants also listed them as ways to improve mental health. These include deep breathing and meditating. Responses regarding relaxation techniques were relatively consistent, at 6% (n=14) at the pre-test, 4% (n=7) at the post-test, and 7% (n=15) at follow-up.

Some participants did express maladaptive behavior as ways to deal with mental health issues. This increased slightly from 4% (n=10) at pre-test to 7% (n=13) at post-test, and 7% (n=15) at follow-up. Such behavior included avoiding people or problems that causes stress, medication,

isolation, doing nothing, forcing oneself to like something or feel a certain way, keeping quiet, and scratching self. While not especially frequent, the prevalence of these ideas for coping underscore the need for the program as a comprehensive strategy to address good mental health development.

By far, the results of Question F show that participants retained and embraced much of the information they learned regarding positive ways to improve their mental health. Talking to others, expressing themselves, and thinking about their situations are key strategies that would enable them to achieve better emotional well-being. Furthermore, identifying specific ways to change their habits and activities ensures such improvements are achievable.

Figure 14. Question F: List 3 things you can do to improve your mental health.



Salience Analysis

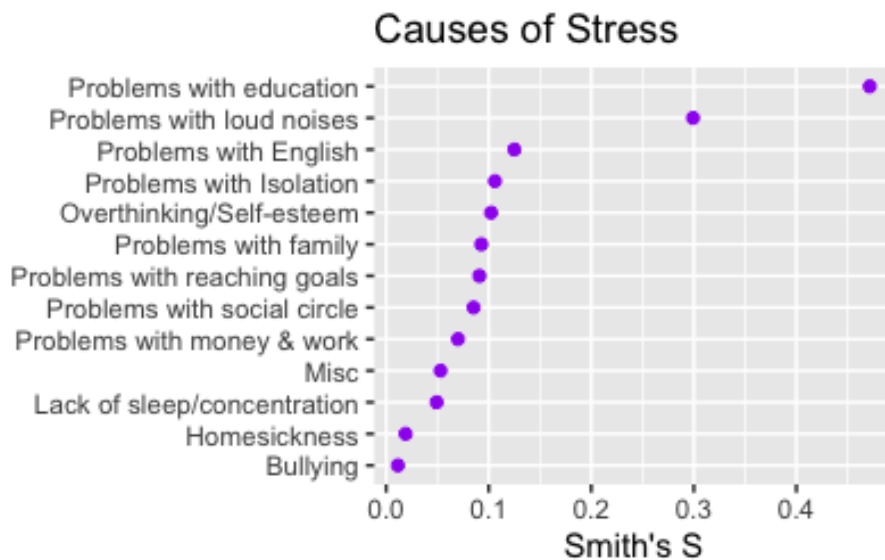
As discussed above, for the open-ended questions, students were asked to list up to three *causes of stress*, *coping techniques when stressed*, and *perceived methods to improve mental health*. Responses were re-coded deductively and inductively by three coders. To further evaluate responses, data were analyzed using salience analysis with AnthroTools package in R. Salience analysis is a method used to identify the main items in a domain by computing a score

for each item that reflects both the frequency and order of mention (Placek et al., 2023; Quinlan, 2005; Weller and Romney, 1998). The cut-off for salience in each population is determined by a Smith’s S score of ≥ 0.10 (Purzycki et al., 2018). Below are results with a Smith’s S score ≥ 0.10 across each time point.

Causes of Stress (Pre-Test, Question B)

There were five salient causes of stress at pre-test. These included: problems with education (0.47), problems with loud noises (0.29), problems with English (0.12), problems with isolation (0.11), and overthinking/self-esteem (0.10).

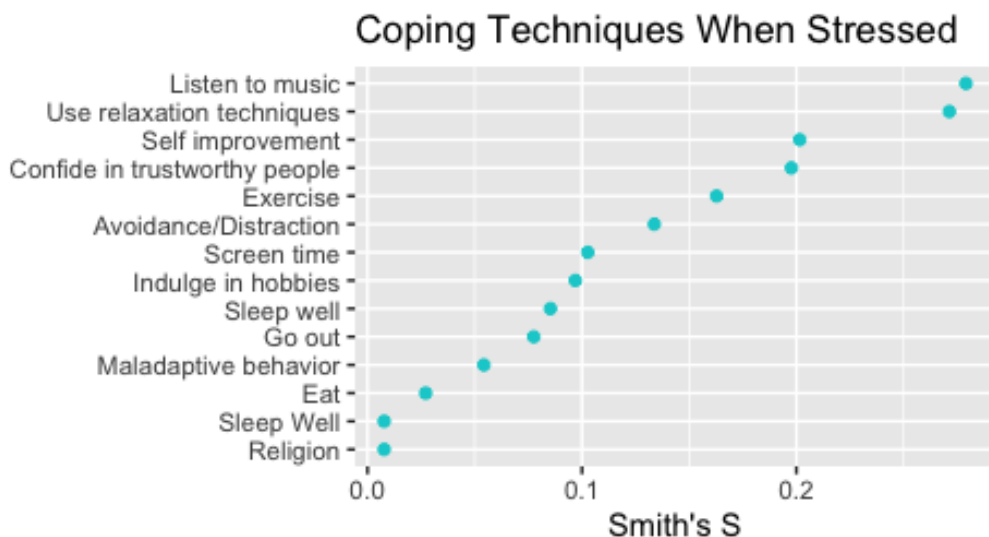
Figure 15. *Smith’s S Scores for Causes of Stress at Pre-test*



Coping Techniques When Stressed (Pre-Test, Question C)

There were seven salient coping mechanisms for stress at pre-test, including: listening to music (0.28), using relaxation techniques (0.27), self-improvement (0.20), confiding in trustworthy people (0.20), exercise (0.16), avoidance/distraction (0.13), and screen time (0.10).

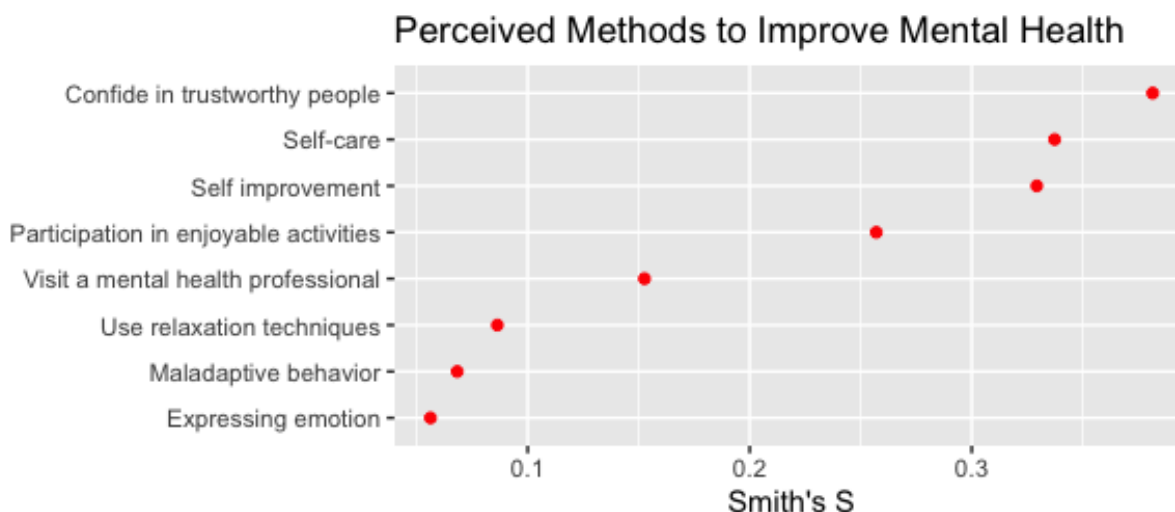
Figure 16. Smith's S Scores for Coping Techniques When Stressed at Pre-test



Perceived Methods to Improve Mental Health (Pre-Test, Question F)

There were five perceived methods to improve mental health at pre-test. These included: confiding in trustworthy people (0.38), self-care (0.34), self-improvement (0.33), Participation in enjoyable activities (0.27), and visit a mental health professional (0.15).

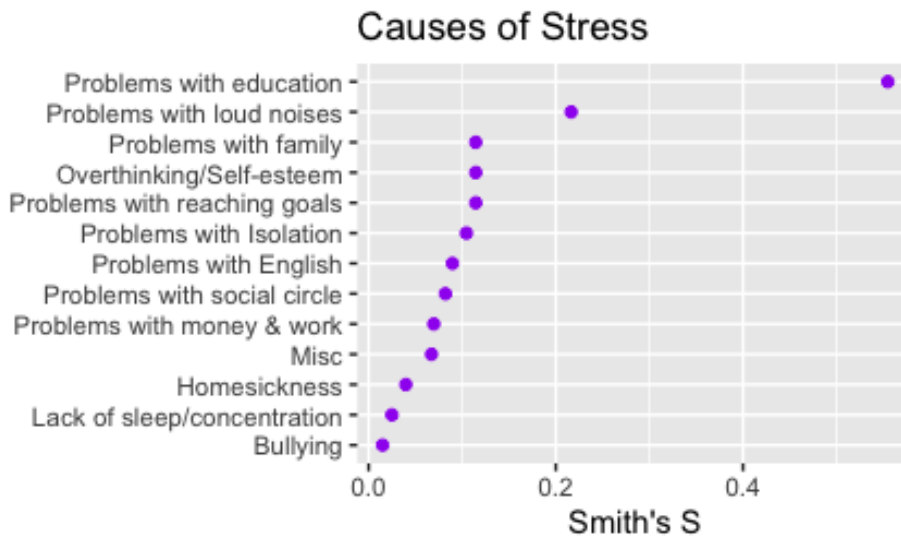
Figure 17. Smith's S Scores for Perceived Methods to Improve Mental Health at Pre-test



Causes of Stress (Post-Test, Question B)

There were six causes of stress at post-test. These included: problems with education (0.55), problems with loud noises (0.22), problems with family (0.11), overthinking/self-esteem (0.11), problems with reaching goals (0.11), and problems with isolation (0.10).

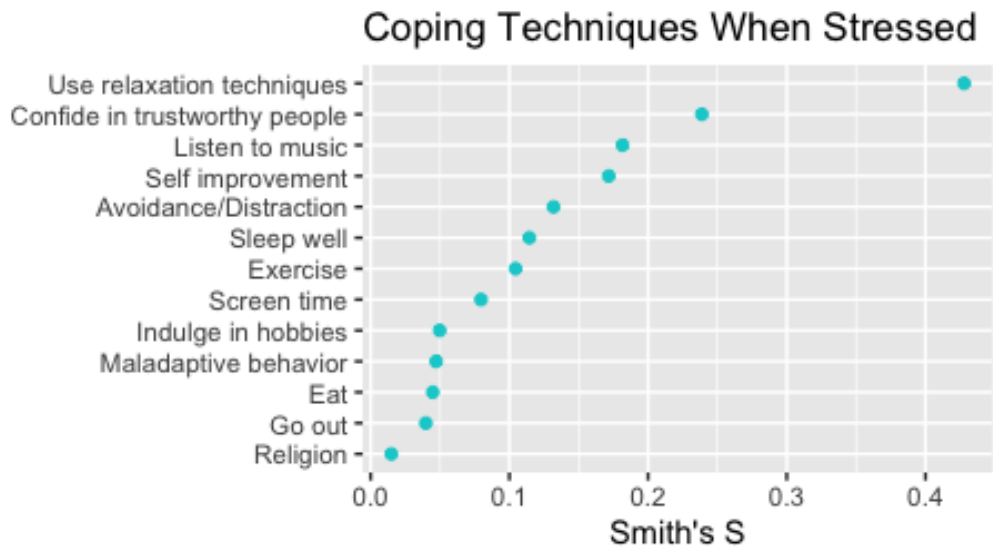
Figure 18. *Smith's S Scores for Causes of Stress at Post-test*



Coping Techniques When Stressed (Post-Test, Question C)

There were seven salient coping techniques at post-test. These included: using relaxation techniques (0.43), confiding in trustworthy people (0.24), listening to music (0.18), self-improvement (0.17), avoidance/distraction (0.13), sleeping well (0.11), and exercise (0.10).

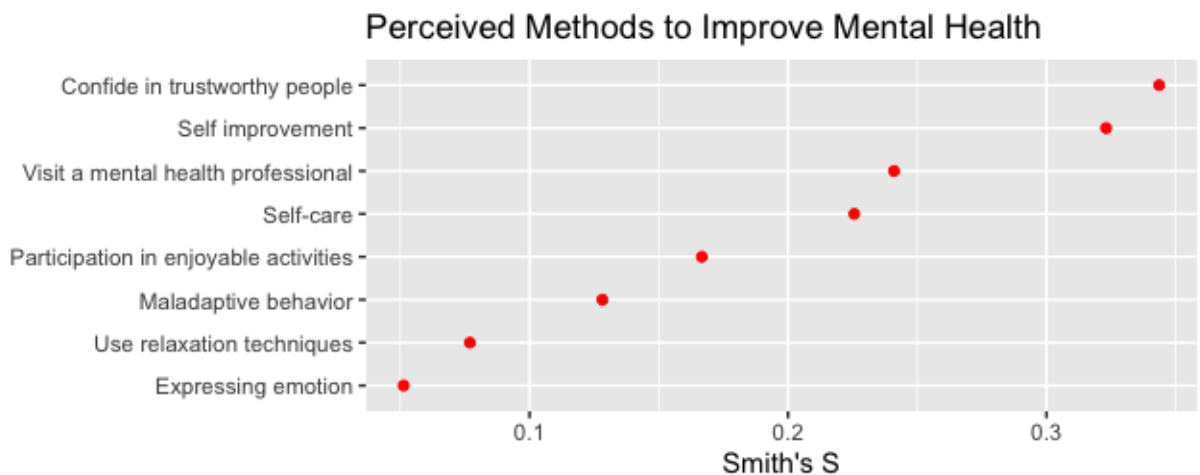
Figure 19. Smith's S Scores for Coping Techniques When Stressed at Post-test



Perceived Methods to Improve Mental Health (Post-Test, Question F)

There were six salient perceived methods to improve mental health at post-test. These included: confiding in trustworthy people (0.34), self-improvement (0.32), visit a mental health professional (0.24), self-care (0.22), participation in enjoyable activities (0.17), and maladaptive behavior (0.13).

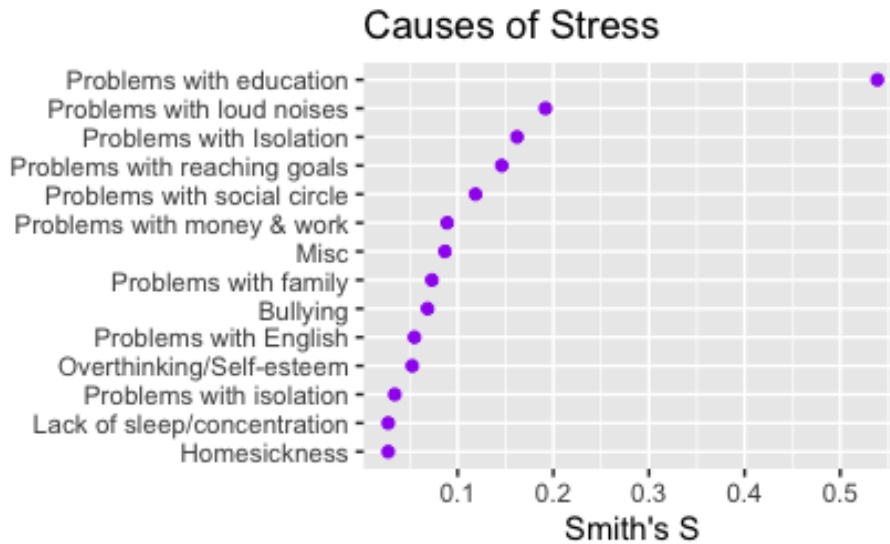
Figure 20. Smith's S Scores for Perceived Methods to Improve Mental Health at Post-test



Causes of Stress (Follow-Up, Question B)

There were five salient causes of stress at follow-up. These included: problems with education (0.54), problems with loud noises (0.19), problems with isolation (0.16), problems with reaching goals (0.14), and problems with social circle (0.12).

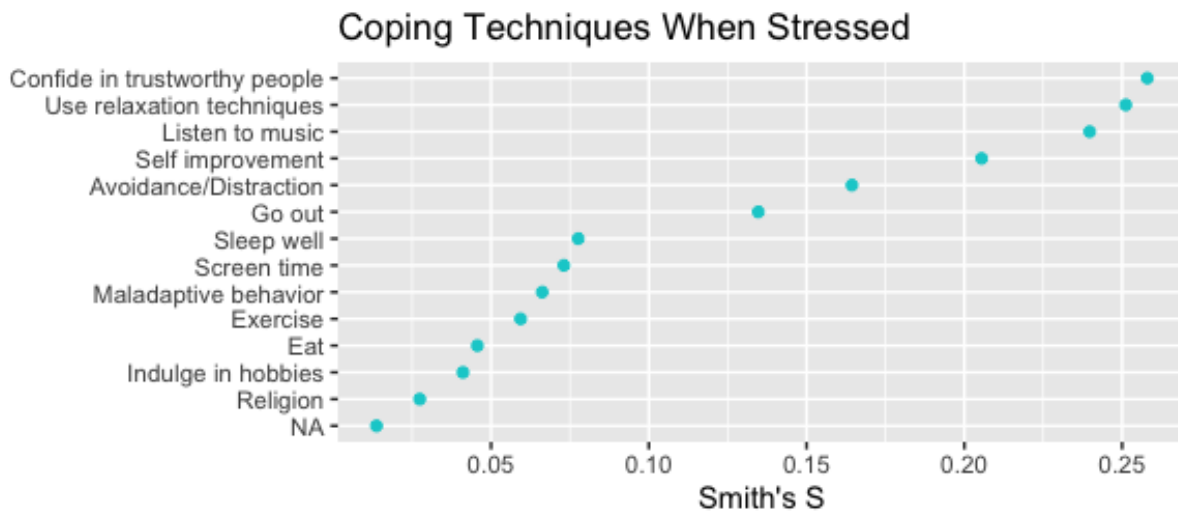
Figure 21. *Smith's S Scores for Causes of Stress at Follow-up*



Coping Techniques When Stressed (Follow-Up, Question C)

There were six salient coping techniques at follow-up, including: confiding in trustworthy people (0.26), using relaxation techniques (0.25), listening to music (0.24), self-improvement (0.21), avoidance/distraction (0.16), and going out (0.13).

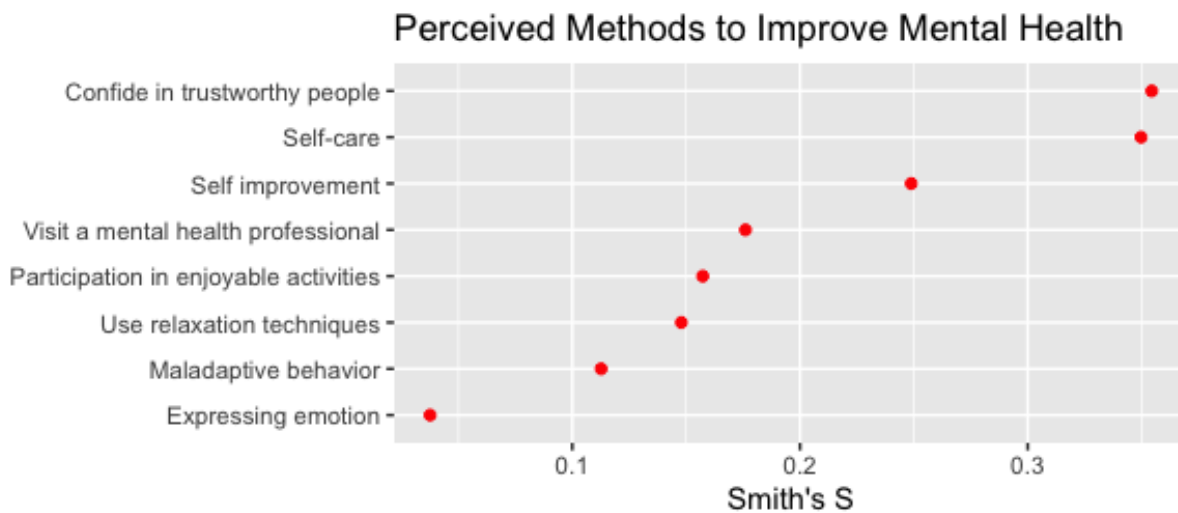
Figure 22. Smith's S Scores for Coping Techniques When Stressed at Follow-up



Perceived Methods to Improve Mental Health (Follow-Up, Question F)

There were seven salient perceived methods to improve mental health at follow-up. These included: confiding in trustworthy people (0.35), self-care (0.35), self-improvement (0.25), visit a mental health professional (0.18), participation in enjoyable activities (0.16), using relaxation techniques (0.15), and maladaptive behavior (0.11).

Figure 23. Smith's S Scores for Perceived Methods to Improve Mental Health at Follow-up



Summary of Findings – Open-ended Questions

Across the three time points, students' primary causes of stress were problems with education, problems with loud noises, and problems with isolation. Education remained the most salient stressor across the three time points. Problems with education include assignments and tests, bad grades, and sometimes relationships with teachers. Many students who reported problems with loud noises reported stressors like yelling, kids crying, arguing, and people repeating the same thing—even their name—multiple times, which could be associated with trauma induced by their immigration journey.

Students also mentioned numerous ways they cope with stress, with key themes including relaxation techniques, confiding in trustworthy people, listening to music, self-improvement, and avoidance/distraction. Relaxation techniques include taking deep breaths; long, cold showers; playing with pets, and meditation. Confiding in trustworthy people could mean talking or hanging out with friends and families. Some students also reported staying in contact with family members back home.

For perceived methods to improve mental health, the primary salient items across the three time points were confiding in trustworthy people, participation in enjoyable activities, and self-improvement. Students who perceived self-improvement as a method to improve mental health reported activities such as thinking positively, getting better grades, keeping a healthier lifestyle, and avoiding negative thoughts and bad influences.

These results should be considered by stakeholders who are interested in concrete ways to mitigate the youth's stressors, given the mental and behavioral risks these youth face. The youth themselves have indicated ways they are appropriately dealing with stress, and these healthy coping mechanisms can be reinforced by others. Stakeholders can work to create infrastructure and support for the identified coping mechanisms, including, for example, creating structured opportunities for exercise, improving access to professional counseling, pet therapy, music engagement, or encouraging participation in mentorship programs.

Qualitative – Focus Group & Interviews

We report the theoretical themes of the Bienvenido program through the lens of the qualitative analysis.

Administrators

The following summarizes the responses collected from school corporation staff and Bienvenido program staff (see *Methods*, p.11).

Building connection is a critical element of the program.

- Connection (in school, among friends, and in family) is an implicit and explicit goal of Bienvenido program. It is also an outcome of the program.
- Connection begets confidence. (If participants feel connected and encouraged in the program, it leads to confidence and success in other areas [i.e. extra-curricular activities].)
- The opportunity to speak in Spanish is comforting.
- The Bienvenido program is a much-needed break from academics.
- Community centers/mentor-based services for Hispanic/Latinx students may be a path forward because it provides connection.

Mental and behavioral health is discussed in an accessible way that allows youth to explore themselves and try out changes they may want to implement in their lives.

- The topic of mental health is brought up to normalize it, give language to what they are feeling, and provide resources to manage it.
- The nature of the program is to introduce topics and let students explore if it is relevant to them.
- Youth walk away with practical knowledge and strategies that will help them and others in social relationships.
- Individualized support sessions are a very important complement to the Bienvenido sessions because it allows youth an opportunity to share traumatic experiences in a private, nonjudgmental, Spanish-speaking session.

It is important to be open to content and curriculum changes within the Bienvenido program.

- It is important to look periodically at adding content to the Bienvenido program (i.e. gang-related content).

- Including additional “outside speakers” to provide testimony on a variety of topics is an engaging part of the program. A speaker to address suicide should be considered.

Very few youths will succeed in school without first addressing their significant trauma and mental health needs.

- Mental health needs among newly arrived immigrants are immense. The needs include addressing internalizing disorders like anxiety and externalizing disorders like anger management problems.
- Trauma intersects with the stress of new transitions, all of which undermines success at school (i.e. “I just can’t concentrate.”).
- Poor mental health and trauma negatively affect academics, and doing poorly in academics also affects their mental health and how they feel about themselves. Poor mental health and poor academics feed off each other—they are bi-directional.
- Youth have so much potential, but currently feel very broken.

There is a need for trauma-informed care and trauma-informed discipline in the school setting to provide a context for trauma to be healed rather than exacerbated.

- Youth are notably angrier than in the past—and anger can lead to displacement of anger in unhealthy activities. Anger is also rooted in trauma.
- Youth act “normal” like teenagers, but trauma lies beneath. Youth may not open up immediately, if at all.
- The consequences of any “teenager” mistake are harsher for immigrants due to immigration concerns.
- Learning and applying trauma-informed discipline is a need among school staff. Some schools are more lenient among students; others are not.

External pressures on youth undercut their desire to be at school.

- Low literacy levels and/or learning disabilities affect students’ success and self-efficacy—sometimes it’s an insurmountable barrier.
- Youth walk a line between wanting to work and knowing they have to go to school. They face enormous pressure to earn money to survive. Guardians support them for a very limited time (3-6 months). Then they are on their own, paying for expenses such as rent and utilities. School is perceived as taking time away from work, especially when they don’t understand English at school and don’t perceive themselves to be good at it.
- Anxiety stems from the confusion and disconnect of not knowing how to navigate a foreign system, whether that is their new city, school, or host family.

Parental/guardian support for youth is desperately needed, but internal and external barriers prevent it from being strengthened.

- Participants lack parental/guardian support, but it may not be due to lack of interest among the parents or guardians. Lack of parental/guardian support is tied to lack of transportation and/or lack of a specific contact person, such as a parent liaison.
- Lack of connection among youth and guardians or host family is an enormous issue that underlies all other issues. Many youths do not know their guardian(s), who are often unavailable to guide youth or provide resources due to, e.g., extensive work hours or undocumented status and fear of putting themselves at risk. Many youths also change guardians, making it difficult to establish a relationship and to keep track of their needs (such as immigration, school, or medical issues).
- A big gap is the school’s inability to reach out to current guardians of youth. Restrictions on who the school can contact severely limit the ability to support youth.
- De-stigmatization of mental health is needed among the adult Hispanic/Latinx population because their lack of support for mental health can affect youth (i.e. not wanting their kids to go after school to do mental health-related activities because mental health “means you’re crazy.”).

By encouraging ample in-person connections between staff and students, and undergirding the program with enhanced mental health protocols across the districts, the Bienvenido program will thrive.

- Administrative support for the program is best evidenced by providing time to teachers or parent liaisons to be fully present during Bienvenido sessions. They can be in charge of managing behavioral issues, and they can support the Bienvenido facilitator with taking attendance and completing the pre-test and post-test with students.
- Time and scheduling adjustments could help the flow of the Bienvenido program (i.e. adding another session in order to complete paperwork, negotiating more than 45 minutes for each session, etc.).
- ESL teachers are asked to help with mental health and integration needs, but they don’t have the support to help (i.e. their full load of classes prevents them from being present in the Bienvenido classes). They need specific guidelines, structures, and protocols on a district level that would provide support—and ESL teachers should be able to provide input into those policies.

Schools are an axis for students to learn about school and community resources, but that opportunity is not currently being leveraged to the degree it could be.

- There is a need for a deeper investigation into what resources exist at the schools, how to increase awareness of the resources among all parties (teachers, parents, students), and how to streamline access to the resources.

- Community-based mental health services are overwhelmed (and participants are waitlisted)—underscoring the importance of help within the context of the schools.
- Field trips to introduce youth and adults to community resources is helpful.
- Needs are met on an “as needed” basis, but this likely contributes to anxiety among youth. A welcoming protocol with community/school resources integrated would be helpful.

The more staff understand the importance of the Bienvenido program, the better the program runs.

- School staff, including counselors, may need education on why the Bienvenido program is important so they can better help support it.
- Continuous introductions/reminders to the program and its topics are needed at every level (i.e. administrators, parents, staff, teachers, and students). Doing so normalizes and integrates the program into the daily schedule (i.e. the students know they will be leaving class to go to the program and/or individualized support sessions; the teachers are aware and move the students along quickly, etc.).

Additional mental health services are urgently needed within the school context.

- Intensive mental health support is warranted for students, but it needs to happen within the context of the school. This may include individualized support sessions as an extension of the Bienvenido program, as well as services provided by school staff.
- The limited number of individualized support sessions is hugely problematic for the healthy functioning of the youth; without support, youth will endure unresolved trauma. They also risk “feeling stripped naked” by revealing information and then being dropped from accessing follow-up support.

Youths

The following summarizes responses collected from attendees of the Bienvenido program at Goshen High School (see *Methods*, p.11).

The Bienvenido program works because it builds connection among youth.

- Speaking Spanish is a method to build connection and friendships.
- The act of gathering in person together and sharing experiences provides a sense of connection and solidarity among youth.

Practical and logistical considerations can improve the Bienvenido program.

- Consider rooms with more space since there may be a lot of participants during a session (i.e. usually one or two more students join the sessions after the program starts).
- There is not enough time for youth to explore the topics each week. More time is needed, either during the weekly sessions or by increasing the frequency of sessions.
- Youth should be given adequate information about the Bienvenido program so they feel like active participants.

Youths have a passion for learning about mental health and healing themselves and others, but they need the culturally appropriate and bi-lingual resources to do so.

- Youths soaked up information about mental, behavioral, and social health. They loved learning about it—largely because they had never been encouraged to learn about these topics before.
- Youths learned strategies for their own lives, based on the testimonies that were given by other people.
- Youths desperately needed to talk to someone—and the social worker (provided as part of the Bienvenido program) was the first person they felt safe enough with to share the seriousness of their struggles and seek advice.
- Providing greater access to a counselor at school would help normalize seeking help for mental health.
- Youths need and may look for help at school, but without Spanish-speaking resources, they may not access it.

Youth are trying to adapt to the United States, but they are faced with a lack of understanding in return, which feels discouraging.

- Youths need help but may not know how to ask for it, thus they pretend they are fine.
- The adaptation to the United States is a significant challenge for youth (i.e. cultural shock is hard to overcome).
- Youths face discrimination based on their accents or lack of English.
- Youths face overwhelming feelings of isolation and loneliness that make it extremely hard to concentrate at school—“sticks can break the camel’s back.”
- Youths perceive others to not understand the immigrant experience, especially the fact that their home lives are unstable. (At the time of the focus group, some youth openly reported themselves as homeless.)

Youths want to be treated as whole people.

- To combat discrimination, youth want to be instrumental in teaching others about their cultures.
- Youths would like strategies on how to best welcome other Hispanic/Latinx students (i.e. youth volunteered to be guest speakers at a Bienvenido session in order to share their experiences with newcomers).
- Youths want to discover and be recognized for their talents, even when they do not speak English well (i.e. do not reduce Hispanic/Latinx individuals to their ability to speak English or not).

Qualitative – Content Analysis

We describe themes identified regarding participants' immigration journeys through the lens of the social workers who conducted individualized support sessions. First, the social workers report that participants differed in their social demographics and immigration circumstances. Depending on their country of origin, participants attained varying education levels and work experience. There were also several ways immigrants arrived to the United States: on foot, via a caravan, as an undocumented individual, or as an asylum seeker. Some participants were United States citizens but raised in another country. Participants expressed multiple reasons for immigrating to the United States, such as having issues with family, experiencing sexual abuse, looking for better opportunities in life, escaping persecution, and fleeing violence.

Participants' migration processes were not without issues, as they faced trauma during and after their immigration journeys, necessitating mental health services. One participant was sexually assaulted once they arrived to the United States and was labeled as promiscuous by their family. Others faced challenges with adapting to a new culture and environment, learning a new language, and figuring out their living situation. Some individuals lived with immediate family, extended family, or someone outside their family. One student faced eviction and relocation from their living situation multiple times and was essentially homeless while maintaining their work and scholarly responsibilities.

As a result of these hardships, participants experienced feelings of depression and anxiety. These feelings were exacerbated by a lack of social support and recurring feelings of traumatization. Extended family could not replace the immediate family's support, and, for many participants, the nuclear family began to break down upon entering a new culture. Further, participants missed and worried about their families, but often felt rejected or abandoned since they had immigrated alone. These conflicting emotions made them feel lost and unwanted. In addition to a lack of social support, participants experienced issues with loneliness, grief, physical and sexual abuse, experiences with gang activity and crime, and stress from language barriers. There were also acculturation issues, as participants expressed feeling restricted because they were now in enclosed areas or a colder climate.

Some participants employed positive coping mechanisms and had protective factors that limited the impact of these traumatic situations. Some protective factors included faith, engagement in extracurricular activities, and having a positive social life. Regardless, most still suffered from poor emotional well-being and showed signs of symptoms of adjustment disorder, depressive disorder, anxiety or panic disorder, and post-traumatic stress disorder. The issues are multifaceted due to participants' histories of self-harm behaviors in conjunction with substance abuse. Although many participants comprehended the negative consequences of substance use, many utilized drugs and alcohol to cope with their stress.

Individuals were hesitant to look for help because of cultural taboos around mental health services. They were scared to share their story with others and felt pressured to be independent and keep their issues to themselves. Participants also disclosed that they were not aware of available services. Even if they knew about the services they could utilize, mental health services are not accessible to this population due to language barriers, a lack of culturally competent staff, or the unavailability of a guardian to accompany them as underage clients. For example, having one social worker for a high school of over 2,000 students speaks loudly of the barriers students face at the level of communication or support at their school.

Therefore, the Bienvenido program provided necessary but brief intervention in participants' native language, allowing some to share their issues with a professional for the first time. By providing individualized support sessions, the intervention helped participants learn various coping strategies. However, the limited time students had with the social workers is concerning. Follow-up sessions are crucial to maintaining their emotional well-being, as it took some students several sessions to establish trust with the social workers before revealing personal stories about sexual assault and abuse. Subsequently, once students felt comfortable opening up, they no longer had the opportunity to speak with the social workers. Students' lives were left unsettled and unresolved at the end of the program, underscoring the importance of periodic check-ins. Nevertheless, the social workers noted that participants want to progress in life and could do so with additional mental health resources.

DISCUSSION

Substance Abuse

As mentioned earlier, four questions regarding cigarette smoking, electronic vaping, alcohol use, and illicit drug use in students were taken from the Youth Risk Behavior Surveillance System (YRBSS) questionnaire. The quantitative analysis of our results is comparable to the national and statewide data from the YRBSS. According to the CDC (n.d.), 3.8% of the national sample size currently smoked cigarettes and 18% currently used electronic vaping products, such as e-cigarettes and vape pens, on at least one day within the last month. Similar findings regarding cigarette vs. vaping product use were identified among students in the state of Indiana. A total of 4.2% of students currently smoked cigarettes within the last month and 0.7% smoked daily, which is similar to the national average of 0.6% (CDC, n.d.). The prevalence of electronic vaping product use was higher, as 19.1% currently vaped within the last month and 4.2% vaped daily. JUUL, a popular e-cigarette, was released in 2015 (University of Bath, 2022). Since then, there has been a decrease in the percentage of students vaping within the last month, but the number of students vaping daily has increased. In our sample from Elkhart and Goshen Community Schools, more individuals smoked cigarettes than the national and the state average (8%, 7%, and 12% for the pre-test, post-test, and follow-up test, respectively). Nationally, 0.6% of students were daily cigarette smokers and 5.0% of students were daily electronic vapor users. This was consistent in our sample, as slightly more participants used electronic vaping products than cigarettes throughout the pre-test (13% vs. 8%), post-test (8% vs. 7%), and follow-up (14% vs. 12%) periods. This data also shows the highest usage of electronic vaping products and cigarettes at the follow-up, suggesting they may be used as coping mechanisms when support is not available and/or during particularly stressful periods, as data was collected after the Bienvenido program ended and during semester exams.

Table 10. Comparison of current cigarette use and electronic vaping product use, according to different measures

	YRBSS United States	YRBSS Indiana	Bienvenido Participant Survey (pre-test, post-test, and follow-up test, respectively)
Current Cigarette Use*	3.8%	4.2%	8%, 7%, and 12%
Current Electronic Vaping Product Use*	18%	19.1%	13%, 8%, and 14%

*Data in this table refer to different time periods, as described in the text.

Concerning alcohol use, 22.7% of the national sample currently drank alcohol on at least one day within the last month, and 40.1% of these individuals usually obtained the alcohol from someone else, meaning that students generally gained alcohol through social means. Alcohol use in Indiana was similar to the national data, as 20.6% currently drank alcohol within the last

month, and 39.8% of these students received the alcohol from someone else. Our sample is slightly higher than the national and state average, as 29% reported drinking alcohol at least once within the last month in the pre-test. Of note, it was more statistically significant for females to partake in drinking and receiving alcohol. Finally, nationwide, 13.3% of the sample had ever used illicit drugs such as cocaine, inhalants, heroin, methamphetamine, ecstasy, and hallucinogens. In Indiana, there is no data on illicit drug use even though Indiana has been afflicted by the opioid epidemic and has consistently placed in the top half of U.S. states and territories for the highest drug overdose death rate since 2013 (Indiana State Department of Health, 2019). Nevertheless, the majority (>95%) of our sample had never used illicit drugs, as reported in the three time periods (pre-test, post-test, and follow-up). This suggests an opportunity to offer early prevention to new immigrant youth, focusing on coping mechanisms before illicit drugs become a consideration.

Table 11. *Comparison of current alcohol use, according to different measures*

	YRBSS United States	YRBSS Indiana	Bienvenido Participant Survey (pre-test, post-test, and follow-up test, respectively)
Current Alcohol Use*	22.7%	20.6%	29%, 24%, and 24%

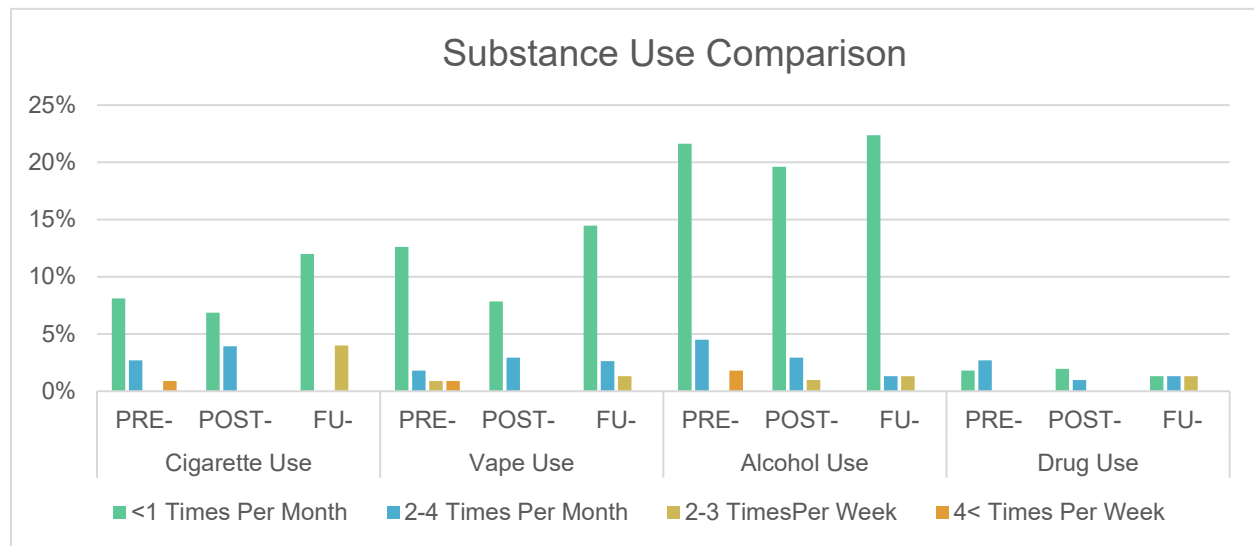
*Data in this table refer to different time periods, as described in the text.

Table 12. *Comparison of illicit drug use, according to different measures*

	YRBSS United States	YRBSS Indiana	Bienvenido Participant Survey (pre-test, post-test, and follow-up test, respectively)
Ever Used Illicit Drugs*	13.3%	No data	5%, 3%, and 3%

*Data in this table refer to different time periods, as described in the text.

Figure 24. A comparison of substance abuse (cigarette, vaping, alcohol, and drug use) among the pre-test, post-test, and follow-up periods in the Bienvenido program



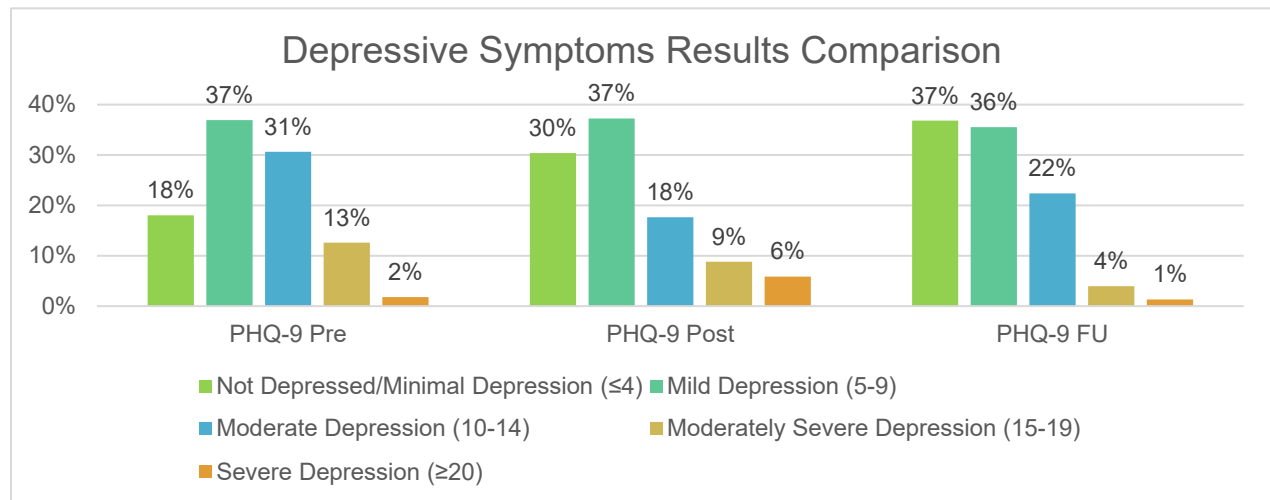
Depression

The results regarding the PHQ-9 scores are consistent with national and statewide mental health data. The prevalence of depression among youth in the U.S. has increased. In 2022, 15.08% of youth have experienced a major depressive episode in the past year, which is more than a 1% increase since 2021 (“The State of Mental Health in America,” n.d.). Further, 10.6% of youth in the U.S. have experienced severe major depression in 2022, and multiracial youth have had a higher rate of severe depression at 14.6%. Looking specifically at Indiana, the state was ranked 38th in the number of youths experiencing major depressive episodes (16.61%) and 48th in the prevalence of youth with severe major depressive episodes (14.5%). In our sample size, 14.4% of participants experienced moderately severe to severe depressive symptoms at the pre-test. This value decreased to 5.2% at the follow-up test, which is less than the national average. These statistics are crucial, as childhood depression is more likely to carry on into adulthood if left untreated, and in the meantime, lead individuals to turn to substance use as a coping mechanism. Seeing that the Bienvenido program helped decrease the percentage of moderately severe to severe depressive symptoms in this sample by more than half shows promise for future cohorts. Consistent follow-up by school social workers may also ensure that students receive support from local mental health providers, such as Oaklawn.

Table 13. Comparison of depressive symptoms/depressive episodes, according to different measures

	PHQ-9 United States	PHQ-9 Indiana	Bienvenido Participant Survey (pre-test, post-test, and follow-up test, respectively)
Depressive symptoms	15.1%	16.6%	15%, 15%, and 5%

Figure 25. A comparison of depressive symptoms among participants based on the PHQ-9 results among the pre-test, post-test, and follow-up periods in the Bienvenido program.



RECOMMENDATIONS

We collectively present recommendations from all sources of data to streamline improvements across the program. We recommend a careful review of the focused codes in Appendix N and O for more specific recommendations.

The first recommendation is to offer both group and individual support sessions conducted by bilingual social workers throughout the school year. The social workers stressed that follow-up sessions were crucial to maintaining students' mental health, so offering sessions outside of the Bienvenido program would be beneficial. Results from the qualitative analysis of the open-ended questions also emphasized the importance of follow-up sessions, as the improvements in coping mechanisms began to diminish by the follow-up period. Further, it is critical to provide these services in Spanish. Results from one mental health intervention program for Latinx parents of troubled youth found that offering services and materials in Spanish was valuable (Ceballos, 2010). Many students in the Bienvenido program expressed that they prefer speaking in their native language, compared to using an interpreter, because it makes them more comfortable disclosing personal information. Ceballos (2010) also noted that parents in the intervention would notice if the facilitator was a Latino immigrant and feel more comfortable confiding in them because they could better understand their concerns. This observation underscores the importance of culturally competent services. Similarly, research suggests that group interventions, such as the Bienvenido program, are more appropriate for Latinos than are individual services. (Ceballos, 2010).

Although some schools are lenient when dealing with immigrant students, others are not. Schools must learn and apply trauma-informed discipline when dealing with immigrant students. Many Hispanic/Latinx immigrant students have also had minimal formal schooling, and schools must prepare them for the classroom experience, while ensuring teachers avoid labeling them as poorly behaved. Subject to having a consistent presence of administrative support from the school to manage behavior, additional trauma-informed care in the schools could be implemented through either counseling or additional staff training. One form of trauma-informed care is trauma-focused cognitive behavioral therapy. This technique is effective and consistent in reducing symptoms of post-traumatic stress disorder and depression, which many Bienvenido participants face during and after their immigration journey (Kataoka et al., 2003). Learning stress management skills via psychoeducation, parent training, relaxation training, affect modulation, cognitive processing, developing narratives of their trauma, mastering feared stimuli, and addressing safety concerns can help participants cope with negative emotions and trauma (Sullivan & Simonson, 2016). Providing greater access to counseling would help normalize seeking help for mental health.

The Bienvenido program must also bolster a sense of connection in participants (in school, among friends, and among family members). Students concluded that gathering in person together and sharing experiences provided a sense of connection and solidarity. This social support is crucial in creating a safe environment for immigrant youth. The program helped participants feel less isolated, and participants reported feeling encouraged to confide in others. However, they also reported increased stress in family relationships and friendships by the end of the program, underlining the need for additional social support. A unique way to develop this sense of connection among participants is to use creative expression therapy. One intervention utilized a drama therapy program that facilitated nonverbal expression among immigrant participants learning English (Rousseau et al., 2007). Students felt empowered by sharing their stories in a safe and comfortable environment. The sense of connection among participants helped enhance their school performance, demonstrating that the self-reported perception of decreased impairment may be associated with improvement in academic functioning. In our focus group results, administrators expressed that poor mental health and poor academics feed off each other in a bi-directional way, so improved academic standing is vital in fostering positive emotional well-being for students. This observation aligns with some of the students' testimonies that on difficult days, the last thing they wanted to do was to go to school, but the Bienvenido classes motivated them to attend school.

Further, we suggest investing in additional or current staff, specifically targeted to assisting immigrant students. Participants expressed that much of their stress derives from school and education, demonstrating the need for extra learning support. Besides hiring more bilingual teachers, schools must invest in mental health service providers. If schools cannot afford to hire more counselors, they can invest in their existing staff and provide them with the skillset needed to address mental health issues. For instance, trauma-focused cognitive behavioral therapy can be administered by individuals without clinical training (Sullivan & Simonson, 2016). Therefore, teachers and other staff can complete training in the psychological techniques required to implement interventions in classroom settings if other personnel are not contracted/onboarded to do so. Teachers should also be entrusted to refer students to mental health programs, which has been done in other interventions and is a way to hold teachers accountable for maintaining relationships with their students (Sullivan & Simonson, 2016). Further, cultural brokers from the community may be beneficial personnel to employ, so that the current staff is not overwhelmed. One study utilized cultural brokers in their intervention to ensure the cultural appropriateness of its implementation (Sullivan & Simonson, 2016). More research is warranted to determine whether these cultural brokers contributed to positive health outcomes. In the Bienvenido program, involving community health workers or more parent liaisons in the program could be beneficial. Another option is to foster relationships with clinicians and community institutions. Kataoka et al. (2003) emphasized the importance of clinicians developing relationships with key administrators and parent liaisons at schools. Partnerships between schools, community centers, and health professionals are vital to identify available resources to community members. Having a grassroots organization as a third party who could manage the Bienvenido sessions is fundamental to creating a sense of community and support for immigrants in these schools. This partnership must be on equal footing, where schools provide

personnel to coordinate schedules and facilitate student attendance at the educational class sessions and individualized support sessions.

In addition to involving more staff, the Bienvenido program should consider diverse ways of reaching out to parents (e.g., through WhatsApp or offering different meeting times at hours when parents are less likely to be working) and increasing parental involvement in the program. Parental support is crucial because there is a positive relationship between parental support and students' resilience (Polat & Kröner, 2022). Hispanic/Latinx culture also values *familismo*, which involves dedication and commitment to family (Ceballos, 2010). Including the family unit in future interventions, including incorporation of their participation in Bienvenido sessions, may be advantageous to fostering social support. For example, program facilitators should consider employing Child Parent Relationship Therapy (CPRT) to promote positive guardian-child interaction (Ceballos, 2010). CPRT is often used as a therapy intervention, and multiple studies have consistently demonstrated its effects in increasing parental empathy and acceptance, reducing child behavior problems, and lowering parent-child relationship stress (Ceballos, 2010).

Similar to Bienvenido, CPRT teaches participants skills regarding therapeutic limit setting, reflection of feelings, and development of self-control, among other topics (Ceballos, 2010). This type of therapy could be useful to both the youth and adult participants in the Bienvenido program, but it may be difficult to involve guardians who have limited transportation and time outside of work. It is crucial to note that though participants lack parental support, it may not be due to lack of interest among the parents. Lack of parental support may be due to lack of time, lack of availability during school hours, lack of transportation, and/or lack of a specific contact person (e.g., a parent liaison), underscoring the importance of investing in more staff or allocating resources to address the social determinants of health. Even if guardians cannot attend the sessions in person, Ceballos (2010) reported that making weekly phone calls with each parent created a sense of *personalismo*. Parents in the study described that the phone call not only made them feel cared for and included, but it also served as a reminder about the program's assignments and meeting time.

Concerning *personalismo*, Hispanic/Latinx students could be part of organizing a welcoming packet for new immigrants. Similar to appealing to parents by contacting them weekly, allowing students to create these relationships with new immigrants would foster *confianza* (trust) between them and support positive emotional well-being (Documet, 2012). The opportunity to interact with Spanish speakers from other countries was mentioned as the first approach to acculturation, so including existing students in the welcoming process for incoming immigrant students may be valuable. As heard in the focus groups, some students were not given in-depth information about the Bienvenido program, making them hesitant to participate. Students who were previously involved in Bienvenido could create testimonies and present the program to new immigrants to foster rapport between them.

It would also be beneficial for program facilitators to negotiate for more than 45 minutes of class time for Bienvenido sessions. Students expressed that the short 45-minute sessions once a week were not enough to delve as deep into the topics as desired. Administrators also brought up the idea of adding another session to complete paperwork. This paperwork session could also be used as a period to introduce participants to each other. Ceballos (2010) found that utilizing the first session to socialize with other participants bolstered a sense of community and connection. This connection is vital, as Hispanic/Latinx communities traditionally value respectful and nurturing interpersonal relationships in groups. Facilitators should also consider providing rapid introductions to those students who are late to join the program, so they can still benefit from the classes and materials.

Regarding program logistics, administrators should conduct a systematic study of the landscape of “resource availability and resource allocation” with the schools as an access point. Participants in the focus groups repeatedly mentioned the importance of resources, but there is a dearth of information concerning how and where to access those resources. Thus, it is vital to investigate what resources exist within the school and community. If school administrators could embed community resources into the school systems, they would be more accessible to students.

Further, a systematic way of managing those resources is necessary, so that staff are aware and can offer services to students in a clear, simple, and organized manner. Providing easy access to resources is crucial due to the reality that many of these youth face. Some have guardians that work more than 48 hours per week, so they do not have reliable transportation to medical or legal appointments. Others have guardians that are undocumented, so they do not want to put themselves at risk for deportation by taking youth to those appointments. Ultimately, as it stands now, the system is haphazard, and students are not receiving the resources they need to prosper both academically and emotionally.

A Norwegian school-based intervention, called Positive Behavior Interaction and Learning Environment in Schools (PALS), is an intervention that utilized a multi-component and multiyear (20 months) approach to create a more prosocial school environment. Although conducting a complex and long-term intervention like PALS is preferred, this method may not be possible for many public institutions that lack the resources and staff.

It may be useful for the program coordinators to contemplate using a different mental health survey instrument in the pre-test, post-test, and follow-up questionnaires for the Bienvenido program instead of the PHQ-9. According to a systematic review conducted by Sullivan and Simonson (2016), school-based interventions often utilize the Strength and Difficulties Questionnaire (SQD) to identify behavioral issues in participants. The SQD is a behavioral

screening questionnaire for 3-16-year-olds that measures emotional symptoms, conduct problems, hyperactivity or inattention, peer relationship issues, and prosocial behavior (YouthinMind, 2012).

Implementation of this questionnaire in the Bienvenido survey instrument may be beneficial, as the current instrument includes themes related to the SQD's scales. However, the SQD only screens for emotional issues rather than depression like the PHQ-9 (Plemmons, 2019). Another possible questionnaire to consider is the PHQ-9: Modified for Teens, which is an altered version of the PHQ-9 to fit adolescent criteria for Major Depressive Disorder (Plemmons, 2019). This version is not research-validated, however, but it may provide more accurate results for adolescents and children.

LIMITATIONS

There are some limitations to address regarding this analysis. First, our study experienced attrition throughout the three different time points. A total of 6 individuals from the post-test data and 30 individuals from the follow-up data were missing. We were unable to administer the follow-up survey instrument to Group 2 from Elkhart High School Freshman Division (n=17) since students were preparing for summer break and graduation. Furthermore, administrators had trouble with program logistics for Group 1 from Elkhart High School Freshman Division because they were the first group they coordinated. Facilitators report a lack of motivation and organization in this sample. As this group approached the end of the program, administrators noted the need for professional intervention by social workers and began providing individualized support sessions to future cohorts. Unfortunately, no students from Group 1 from Elkhart High School Freshman Division benefited from the support sessions. Consequently, the improvements in emotional well-being in Elkhart High School Freshman Division may not be accurately reflected in the statistical or qualitative analysis. Group 1 may have skewed the post-test data from Group 2 since they were combined when conducting the analyses. Additionally, the possible impacts of the individualized support sessions would not be indicated in the follow-up data, as only Group 1 of Elkhart High School Freshman Division completed the follow-up questionnaire. In contrast, 30 of the 39 participants at Goshen High School (Groups A and B) completed the follow-up test.

Regarding our methodology, we utilized the PHQ-9 in the pre-test, post-test, and follow-up survey instrument. However, we omitted one question (Q8: Moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?), because we concluded it would be irrelevant to our study population, of which the majority was students. We corrected the absence of this question so we could still determine the level of depressive symptoms, but utilizing all the questions as intended could have produced more accurate results. Finally, we used the PHQ-9 for our child and adolescent samples to maintain consistency among all our samples, but utilizing the modified version for teenagers may have been a better screening tool since it fits the adolescent criteria for Major Depressive Disorder. However, as noted earlier, the modified version for teenagers is not research-validated.

CONCLUSION

The Bienvenido program helps improve mental health outcomes among immigrant Hispanic/Latinx youth that face trauma before, during, and after their migration journeys. This trauma can include issues with family, emotional or sexual abuse, homelessness, and involvement in gang activity, among other challenges. In some cases, immigrant youths' trauma has gone largely unrecognized by their guardians or schools. These youth are also unable to access mental health care due to barriers such as language, transportation, lack of knowledge, and stigma. Since the immigrant students in Elkhart County and the Northern Indiana community do not receive any education to help them acculturate to American culture, the Bienvenido program is a comprehensive introduction to the skills they need to begin healing. Though the program is built upon an effective curriculum, administrators can implement several improvements. The quantitative and qualitative analyses determined that future iterations of the program should include additional individualized and group support sessions for students, more time for the program's sessions, further investments in staff, and more parent or guardian involvement.

The Bienvenido program is brief, but the healing process for severe to moderate depression, anxiety, and post-traumatic stress disorder can be lengthy. These youth need follow-up individualized support sessions, as well as professional counseling in some cases, to ensure their emotional well-being continues to improve past the program's completion. It is also crucial that the program emphasizes social support and allows students to make meaningful connections with their community, peers, teachers, and guardians to lessen their feelings of rejection and abandonment. Ultimately, it is imperative that the Bienvenido program continues offering services to immigrant youth who face barriers to accessing mental health care. The influx of immigrant Hispanic/Latinx youth in Elkhart County is unlikely to stop, and this vulnerable population will continue to have special needs due to their traumatic circumstances. The Bienvenido program has the capacity to improve immigrant students' mental and physical health, in addition to their academic outcomes, allowing them to acculturate, become part of the community, and better succeed in life. A partnership between school corporations and the Northern Indiana Hispanic Health Coalition will allow the development of a welcome package and make regular Bienvenido classes possible, so that new immigrant students can benefit from them.

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APPENDICES

APPENDIX A: PARTICIPANT SURVEY UTILIZED IN THE BIENVENIDO PROGRAM

BIENVENIDO

Initials: _____
 City: _____
 Date: _____

Participant's Name _____

A. DEMOGRAPHIC INFORMATION

Gender: Male Female Age _____ How long have you lived in the US? _____ / _____
(Now) (In Total)

Home Country: _____
 Last grade completed in your home country? 1st 2nd 3rd 4th 5th 6th 7th 8th 9th

How many years have you worked in agriculture/manufacturing/construction? _____
 Do you have health insurance? Yes No

How well do you speak English? Very well Good A Little Not at all

Instructions

Remember that all information you share is absolutely CONFIDENTIAL. We ask that you are honest with yourself and attempt to answer all of the questions.

A. Please indicate how much you agree with each of the following situations (scenarios).

		Strongly Disagree	Disagree	Agree	Strongly Agree
1	I feel like I am a person who is just as valuable as everyone else.				
2	I feel like I have many good qualities.				
3	I have a feeling that I don't have much to be proud of.				
4	In general, I'm satisfied with myself.				
5	I know enough about the adaptation process of living in the United States.				
6	I know the meaning of the terms "mental health," "mental illness," and "substance abuse," and I can explain them to someone else.				
7	I think life is just hard. I have to accept things like they are and not worry or get depressed.				
8	I think that someone who overreacts to stress is probably crazy or not doing enough to get better.				
9	Drinking alcoholic beverages, smoking tobacco, vaping, or using other drugs is simply normal and an easy way to reduce stress.				
10	In difficult moments I have a trusted adult I can go to.				
11	There are people who ask for my help.				
12	I have someone I can talk to about important decisions in my life.				
13	I have people who have the same interests and concerns as I do.				

B. List 3 situations that may cause you stress.

a. _____

b. _____

c. _____

C. List 3 things you can do so to keep the situation from getting out of control when you begin feeling stressed.

a. _____

b. _____

c. _____

D. During the last 2 weeks, how often ...?

	How frequently...?	No days	Several days (less than 6 days)	More than half of the days (between 7 and 10 days)	Almost every day (between 11 and 14 days)
1	Have you had low interest or pleasure in doing things?				
2	Have you felt down, depressed, or hopeless?				
3	Have you had difficulty staying or falling asleep or have you overslept?				
4	Have you felt tired or had low energy?				
5	Have you had no appetite or have you overeaten?				
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down?				
7	Have you had difficulty concentrating or memorizing school material?				
8	Have you had thoughts that you'd be better off dead, or of harming yourself in some way?				
9	Have you participated in community service activities or as a volunteer or in extracurricular activities at school (such as clubs or sports)?				
10	Have you received a disciplinary sanction at school?				
11	Have you attended a professional counseling session?				

E. Mark the answer that best fits your current situation, within the last 30 days:

	How frequently...?	Never	1 time per month or less	2-4 times per month	2-3 times per week	4 or more times per week
1	Do you smoke or have you smoked cigarettes?					
2	Do you use or have you used an electronic vaping product? (For ex., e-cigarettes, vape pens, vapers, e-hookahs)					
3	Do you drink or have you drunk an alcoholic beverage?					
4	Do you use or have you used illicit drugs?					

F. List 3 things you can do to improve your mental health.

- a. _____
- b. _____
- c. _____

G. During the COVID-19 pandemic, how frequently was your mental health poor? (Poor mental health includes stress, anxiety, and depression.)

- a. Never
- b. Rarely
- c. Sometimes
- d. Most of the time
- e. Always

H. During the COVID-19 pandemic, did one of your parents or another adult at home lose their job, even for a short period of time?

- a. My parents or other adults at home did not have a job before the pandemic started.
- b. Yes
- c. No

APPENDIX B: FOCUS GROUP AND INTERVIEW QUESTIONS FOR ADMINISTRATORS AND STUDENTS

Focus Group/Interview Questions for Administrators (school corporation staff and Bienvenido program staff)

1. The results of the program seem promising. They show gains in self-esteem and coping mechanisms among participants. Why do you think the program is impactful?
2. Tell me about facilitating the program. What was hard about facilitating the program? How did you overcome those challenges? (only for facilitator)
3. Was it hard to talk about mental health throughout the program? Did it get easier to talk about mental health over time? What made it easier?
4. What other topics were hard to talk about? Why? What did you do to overcome that challenge?
5. In what ways could the program be improved?
6. What seemed to be the most important part of the curriculum for the youth that participated?
7. Tell me about the individualized support visits. How did you identify those who needed more help?
8. What would you like to see happen among participants because of this program?
9. What would you like to see school and elected officials do to help the participants of the program?
10. What would you say are the three major challenges participants face in their lives?
11. What supports do the youth need that don't currently exist in the community?
12. What did you learn about the participants' immigrant experience that you didn't know before? Is their decision to come to the USA or did their family plan the trip for them?
13. Did your experience in this program move you to action in any way?
14. What were the barriers participants faced when engaging fully in this program?

15. What were the barriers you as administrators faced in running the program?
16. What would you like to see changed in future iterations of the program?
17. What would this program need to make it sustainable over the long term?
18. Based on your experience interacting with those kids, what do you think that can happen to the students that don't get follow-up individualized support sessions?
19. How at-risk do you perceive these kids to be (i.e. hunted by gangs members or getting involved in crime)?
20. Do you feel a pattern among the immigrant students in general? How does their age affect the struggles they face? What is the same, what is different?
21. Do you perceive that the participants are on the right track for a successful acculturation process? If yes/no, why?
22. What were the barriers you faced in running these individualized support sessions? (only for social workers)
23. What is the profile of new immigrant students arriving to the USA and specifically to your school?
24. Does the school have a protocol to welcome them?
25. What criteria did you use to select the kids that need to attend the class?
26. What was hard about scheduling/keeping track of the attendees? How did you overcome those challenges?

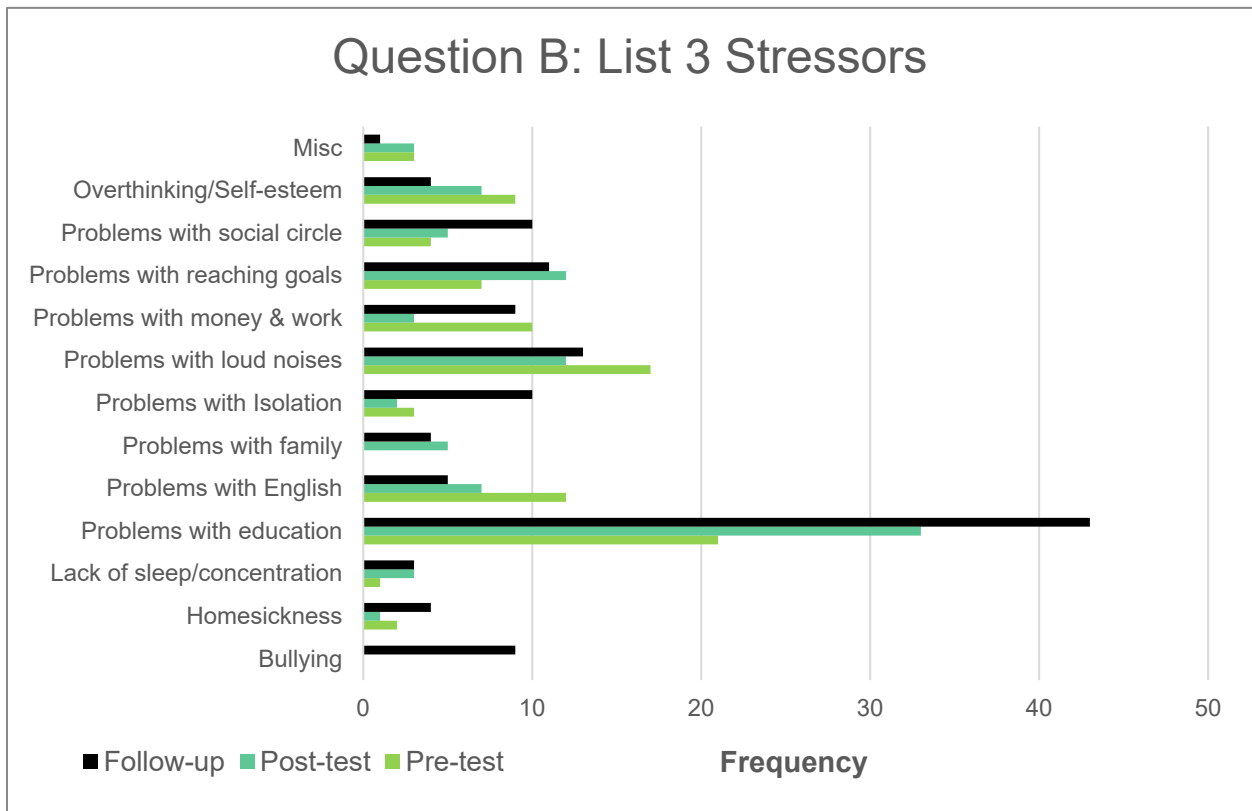
Focus Group Questions for Students

1. The first question is what did you like most about the program? (La primera pregunta es ¿Qué es lo que más les gusto del programa?)
2. What session did you like most? (¿Cuál sesión les gusto más?)
3. What were your experiences like with the social workers? Did you want the sessions to continue? (¿Qué tal les pareció las sesiones con las trabajadoras sociales? ¿Les gustaria que continuaran las sesiones?)

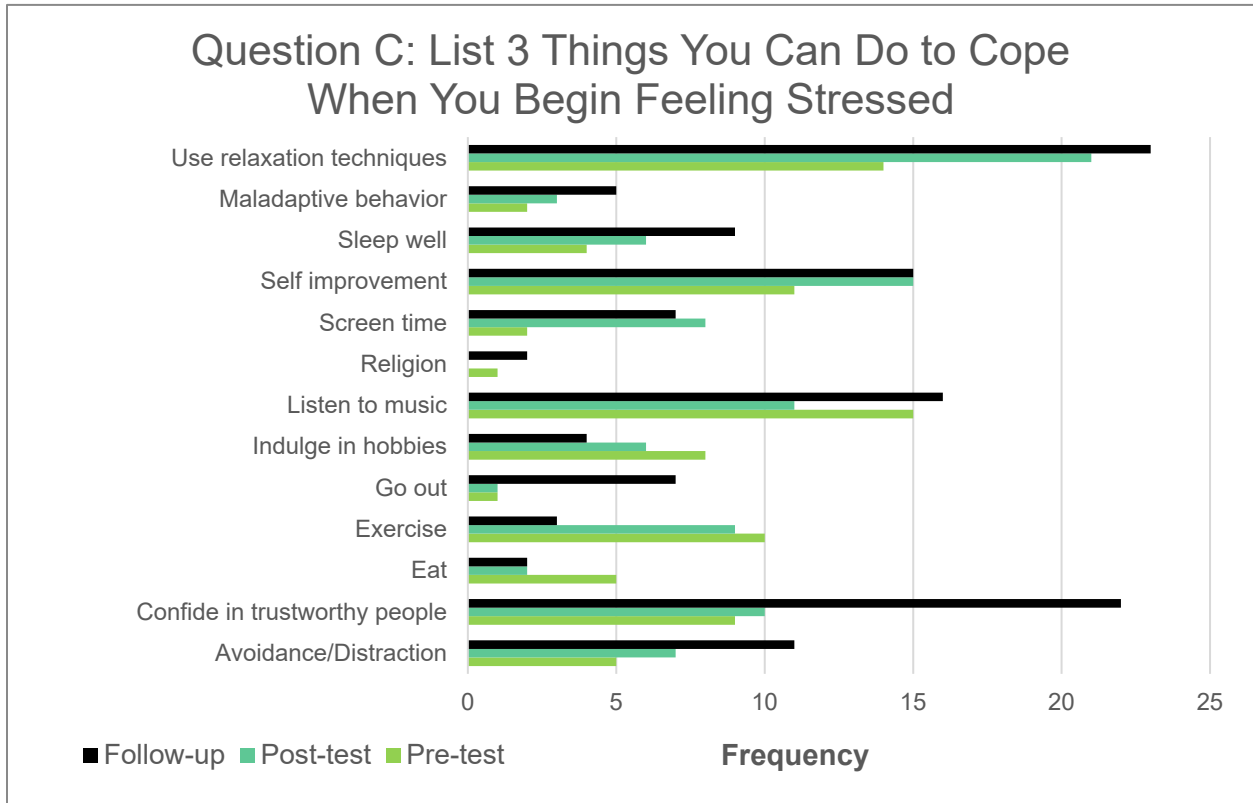
4. I want to touch on the topic of mental health. Was it difficult to talk about your feelings? Why or why not? (Quiero preguntarles sobre el tema de salud mental. ¿Fue difícil hablar de sus sentimientos y experiencias? ¿Por qué sí? y ¿Por qué no?)
5. How could we improve the program? What would you change about the program if you had the chance? (¿Cómo podríamos mejorar el programa? ¿Qué cambiarían del programa si tuvieran la oportunidad de hacerlo?)
6. We want to ask how you might have changed after your participation in the program. What changed in your life or in the way that you think after you participated? (Queremos saber ¿en qué sentido cambiaron ustedes después de participar en el programa? ¿Qué cambió en sus vidas o en su manera de pensar después de participar en él?)
7. Please list three things that you learned from the program. (Podría listar 3 cosas que aprendió en el programa.)
8. What are the three greatest challenges right now in your lives? (¿Cuáles son los 3 desafíos más grandes en sus vidas?)
9. What do you think you need to have success at school for this year and the next? (¿Qué creen que necesitan para tener éxito en su vida académica este año y el próximo año?)
10. What do you think you need to have success in your personal life for this year and next? (¿Qué creen que necesitan para tener éxito en su vida personal este año y el próximo año?)
11. What do you want the adults in your life to know about the process of assimilation in the United States? (¿Qué quieren que sepan los adultos en su entorno sobre el proceso de asimilación o adaptación a la cultura de los Estados Unidos?)
12. What do you want the adults in your life to know about the life of an immigrant? (¿Qué quieren que sepan los adultos en su entorno sobre la vida de un inmigrante?)
13. What makes Goshen High School (GHS) a good place to be a student? (¿Por qué es GHS un buen lugar para estudiar?)

14. What does GHS do for immigrant students that has made you feel welcome? (¿Qué ha hecho GHS por los estudiantes inmigrantes que los hace sentir bienvenidos?)
15. What do you wish GHS had done for you as a newly arrived immigrant? (¿Qué le gustaría que hiciera GHS por nuevos estudiantes inmigrantes?)

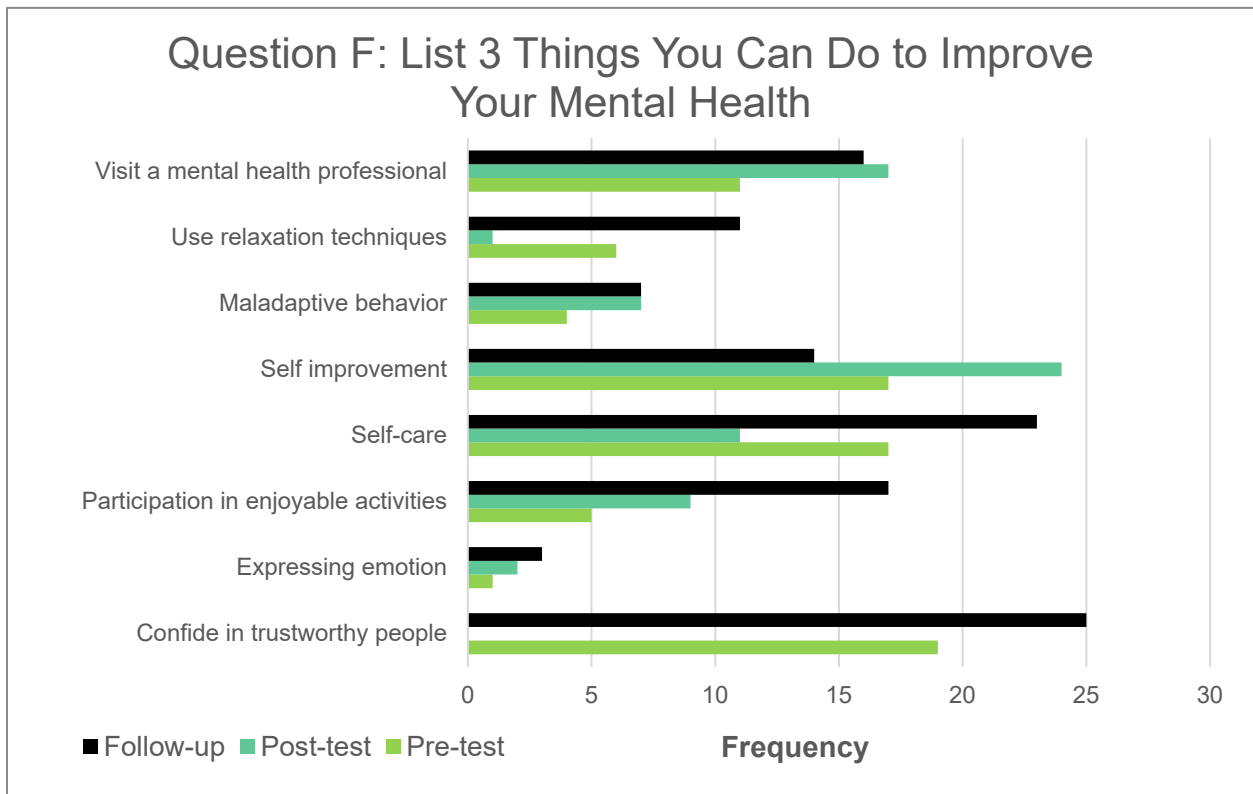
APPENDIX C: THE STRESSORS REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT



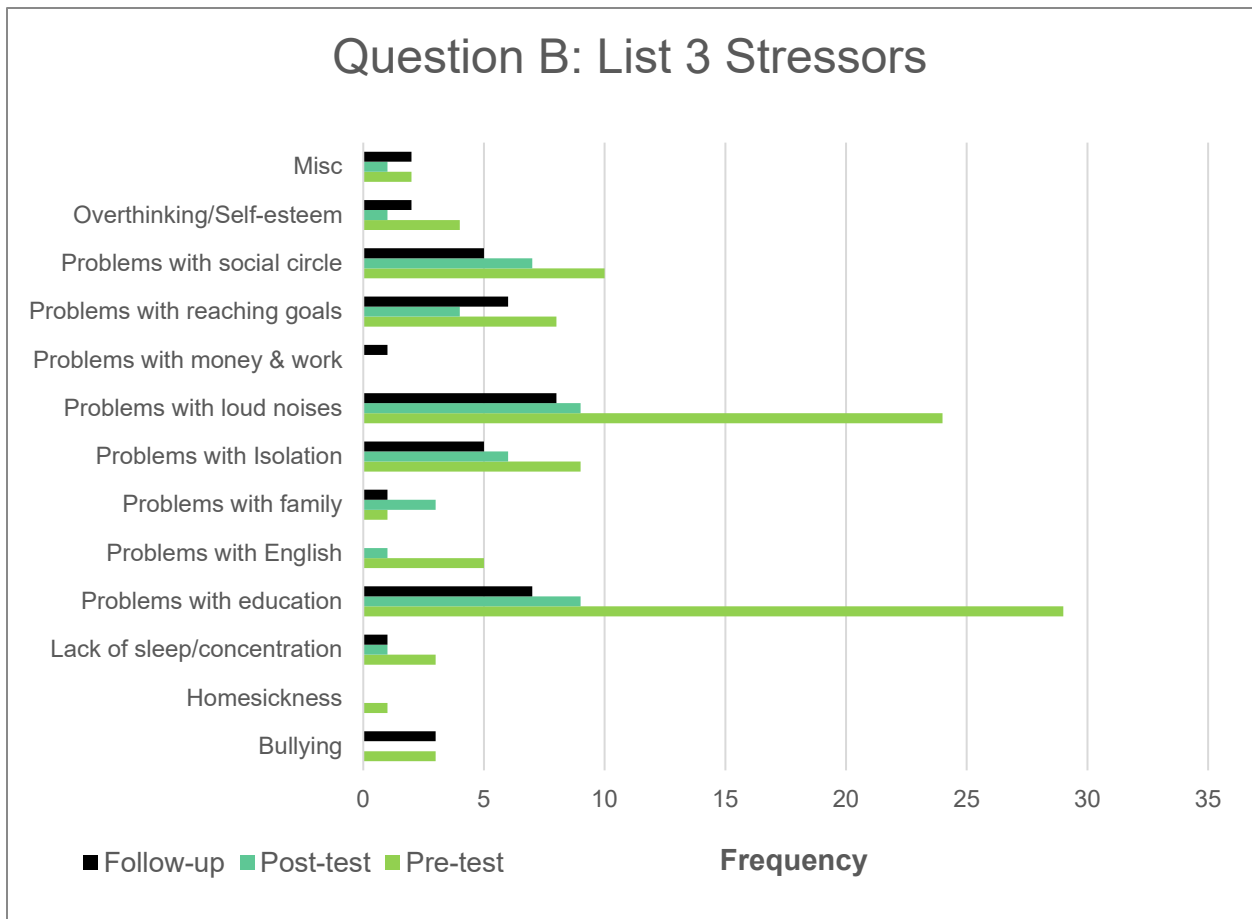
APPENDIX D: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT



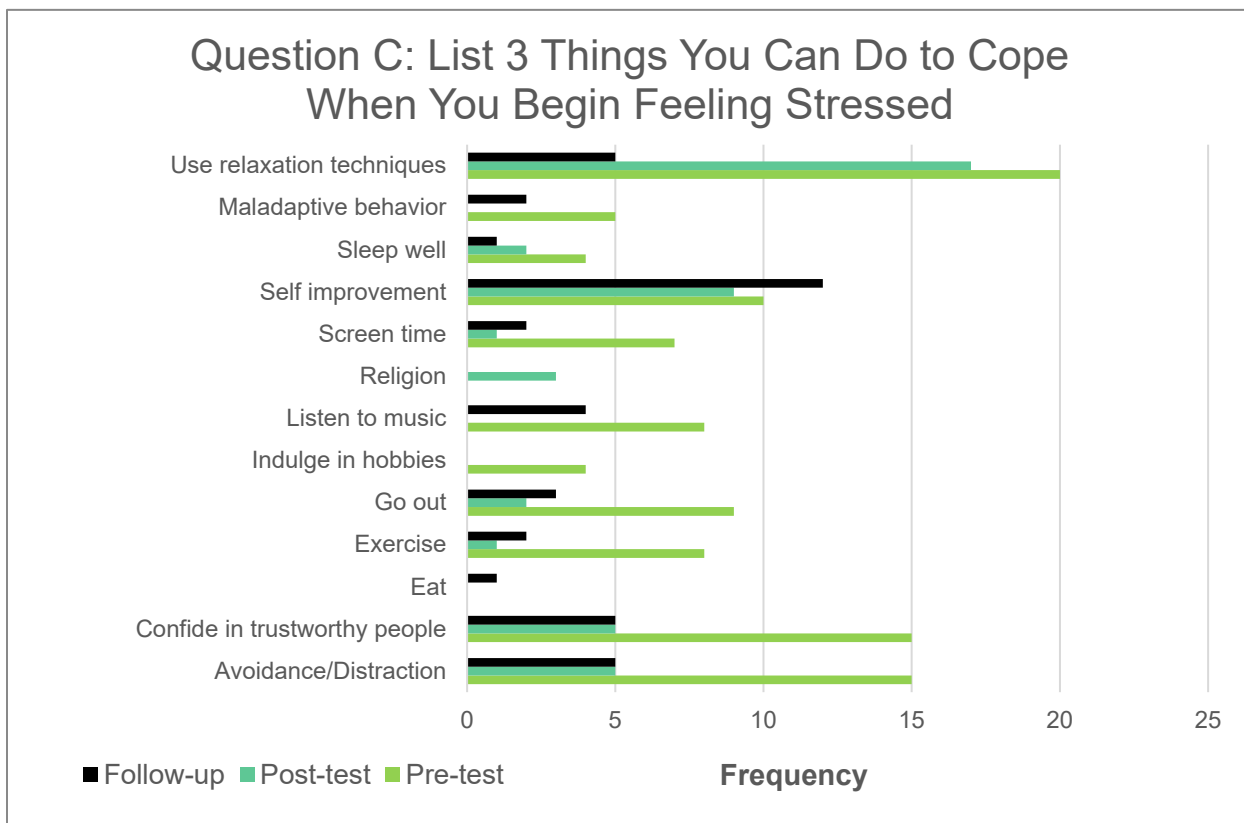
APPENDIX E: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM GOSHEN HIGH SCHOOL AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT



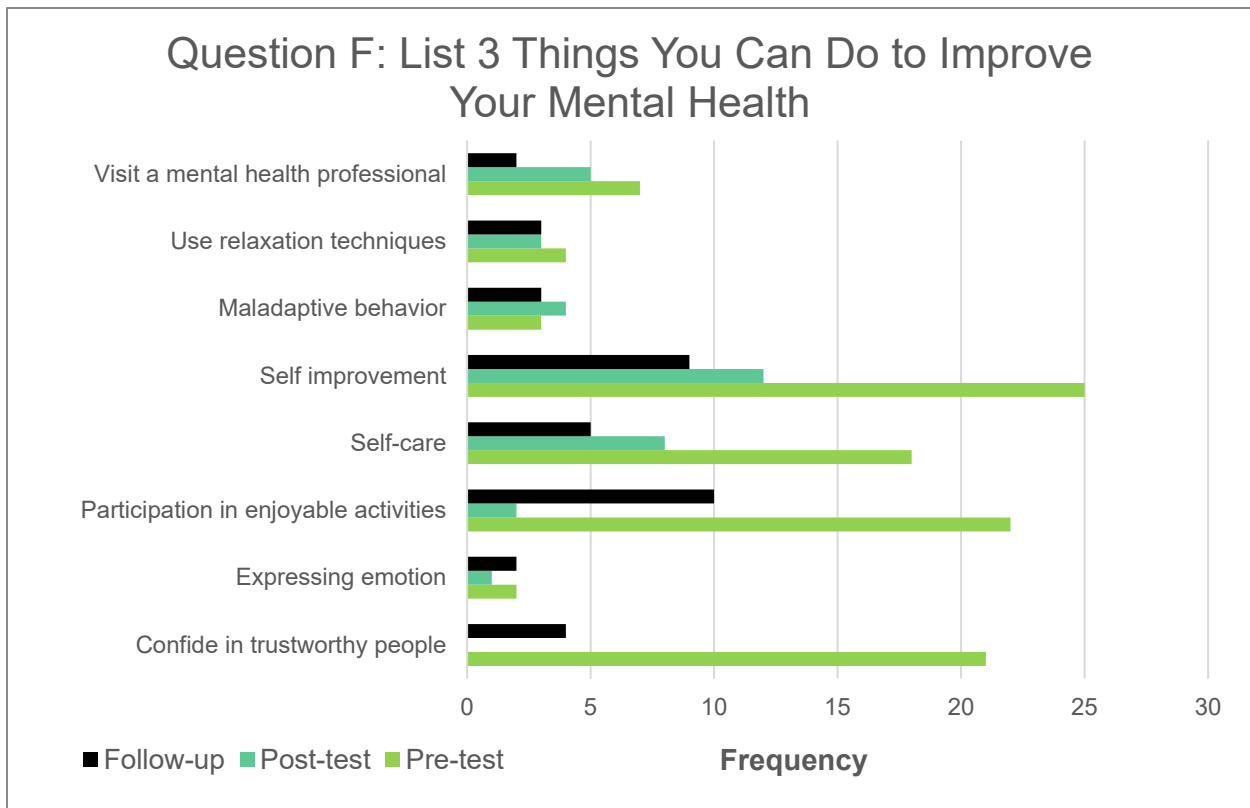
APPENDIX F: THE STRESSORS REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT



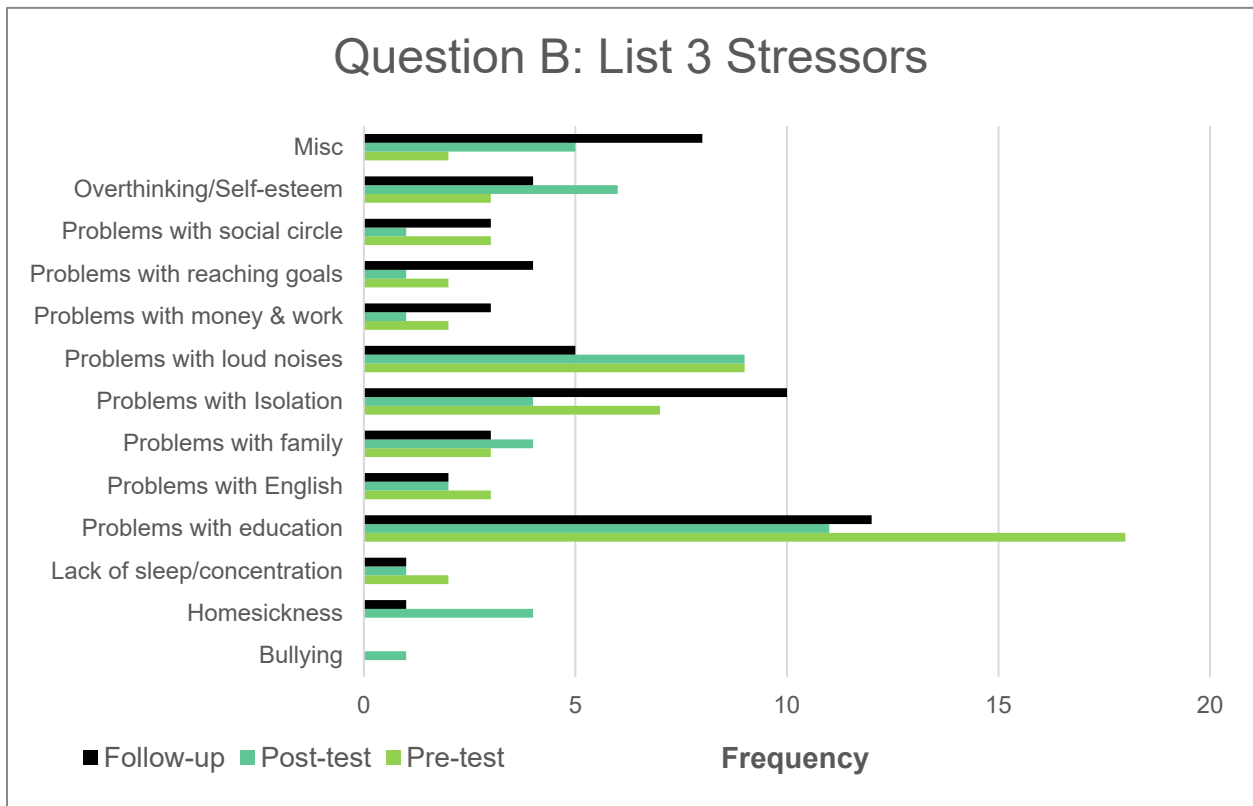
APPENDIX G: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT



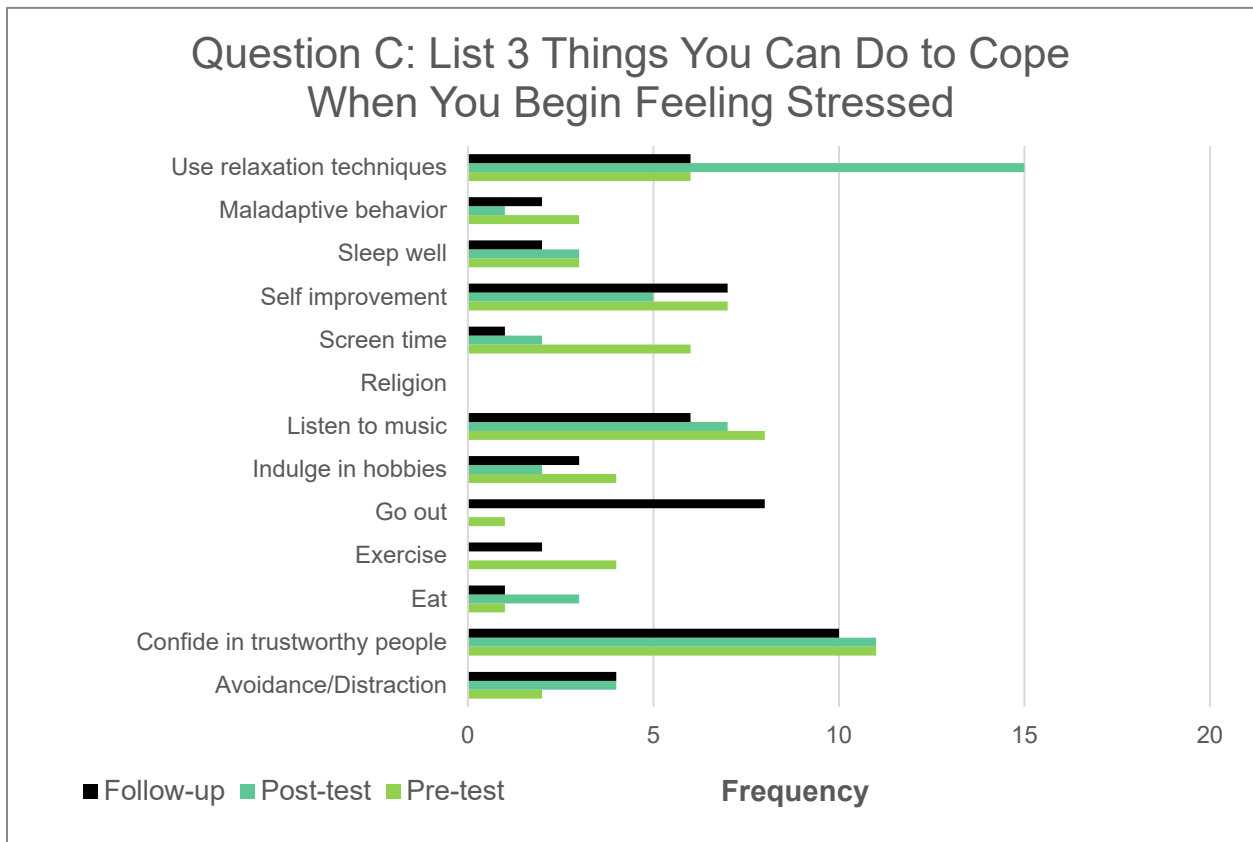
APPENDIX H: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM ELKHART HIGH SCHOOL FRESHMAN DIVISION AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT



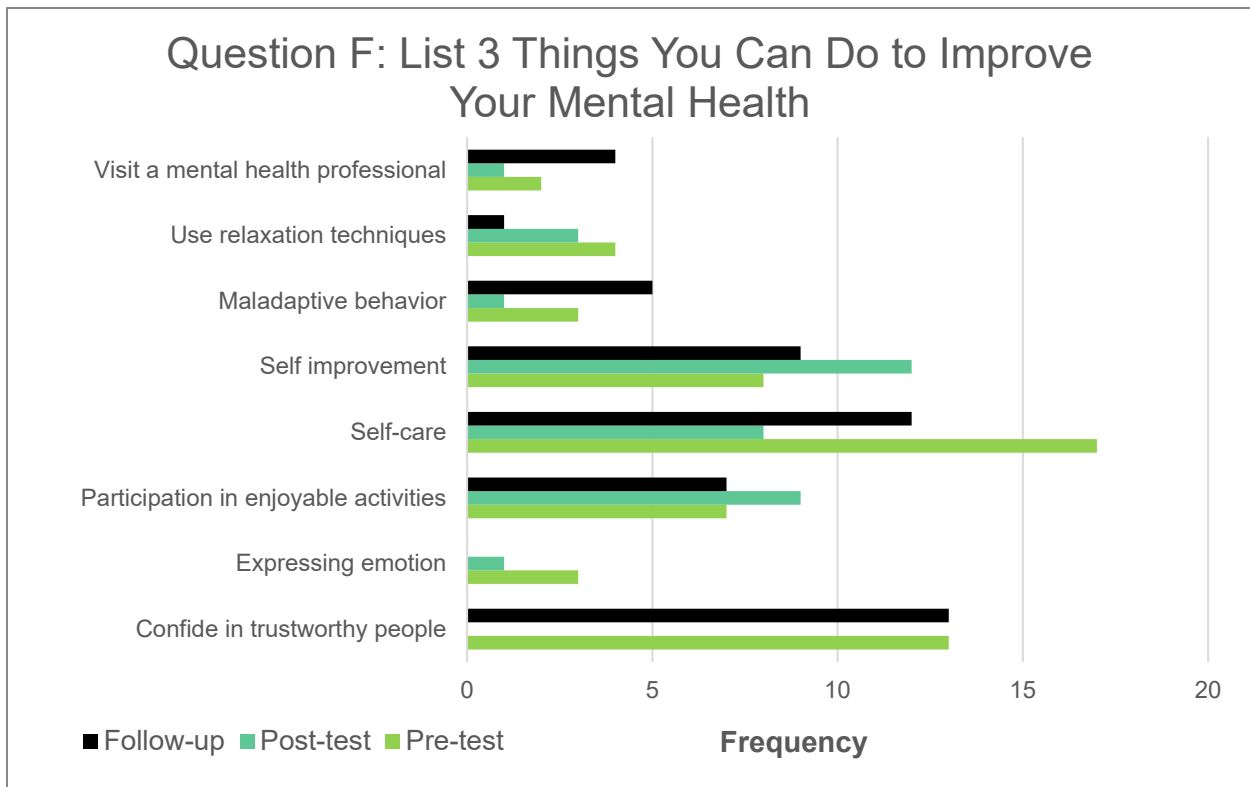
APPENDIX I: THE STRESSORS REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT



APPENDIX J: COPING MECHANISMS REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT



APPENDIX K: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY PARTICIPANTS FROM PIERRE MORAN MIDDLE SCHOOL AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT



APPENDIX L: LINE-BY-LINE CODES FROM THE ADMINISTRATORS' DATASET (SCHOOL CORPORATION STAFF AND BIENVENIDO PROGRAM STAFF), DEVELOPED FROM TWO FOCUS GROUPS AND TWO ONE-ON-ONE INTERVIEWS; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE

Name	Description	Files	References
Administrative support for program		0	0
Administration support is important		1	2
Time blocked off to coordinate		1	1
Biggest challenges of youth		0	0
Adults		1	1
Housing and transportation		2	2
Lack of resources		1	3
Language		1	1
Mental health		1	1
Parental involvement		2	5
Parent liaisons are important		2	3
Parents are stressed		1	1
Community services are overwhelmed		2	4
Community coalition for Latinos		1	3
EL teachers are overwhelmed		2	4
Lack of school awareness of migrant youth needs		1	1
Negative case		1	1
What schools could do additionally		3	4
Individualized support sessions		0	0
Appreciative of having the experience to share		1	4
Kids were slower and more distrustful		1	4

Name	Description	Files	References
Classes pairing with counseling		1	2
Couldn't do treatment		1	1
Limited follow-up is concerning		1	6
Risk of being stripped naked		1	4
Opening up for first time		1	1
Provided coping skills and resources		1	2
Desires for participants		0	0
Connect with parents		1	1
Finish high school and pursue future		1	2
Integration in school		1	1
To feel part of a community		2	2
To improve mental health		1	1
Having control over school can feel good		1	1
Immigrant experience		0	0
Anger		1	2
Being scared		2	2
Confusion on navigating the community		1	1
Introduction to community resources is needed		1	1
Currently there is no organized system of welcoming		1	4
Cultural shock		1	2
Importance of Spanish		2	3
Lack of academic preparation		3	3
Established family means greater academic success		1	1
Experience varies by country		1	1

Name	Description	Files	References
Immigrant experience is more intense than in the past		1	3
No connection, more struggles		1	3
New, unknown relationships		2	5
PTSD - Trauma		2	8
Kids might not show how they are feeling inside		1	3
Lack of motivation among youth		1	3
Impact of program		1	2
Builds community		1	2
Chance to focus on mental health		2	6
Gives needed encouragement		1	1
Keeps marginalized at forefront		1	1
Kids learn things that are helpful		2	3
Sense of solidarity		1	1
Success compound		1	1
Teaches about services that are available		1	2
Testimony shared by guest speaker was important		1	2
Kids don't see importance of school		2	5
Trying to survive		1	1
Mental health and academics are intertwined		2	6
Mental health is stigmatized		3	5
Need for program		2	3
Facilitators as guides		1	2
Gives mental health a space to be discussed		2	5

Name	Description	Files	References
Help others, not just themselves		1	1
One mistake can cost a lot		1	3
School can't connect with guardians		2	3
Trauma informed care		1	6
Ways to improve		0	0
Allow EL teachers to participate		1	1
Incentives to fill out paperwork and surveys		1	2
More time		1	2
Need to create more content on gangs		1	1
Promote greater awareness of program		2	6
Scheduling challenges		3	8
Use time wisely and fluidly		1	1

APPENDIX M: LINE-BY-LINE CODES FOR THE STUDENTS' DATASET, DEVELOPED FROM ONE FOCUS GROUP AND TWO ONE-ON-ONE INTERVIEWS; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE

Name	Description	Files	References
Comfort in own language		1	4
Individualized support sessions		0	0
“didn’t have anyone” so it was nice to talk to someone		1	6
Bounce ideas off of		1	2
Need to normalize going to mental health care provider		1	1
Private opportunity to share		1	2
Future ideas		0	0
Need a welcome		1	1
Opportunity to explore talents		1	1
Want to share their culture		1	3
How they want to be perceived		0	0
Brave		1	1
Doing difficult things		1	1
Improvements		0	0
Desire for more time and longer classes		1	5
Kids haven’t been well-informed about the Bienvenido program		1	2
Need bigger class space		1	1
Liked about the program		0	0
Liked sharing life experiences		1	7

Looking for help at school		1	1
Mental health		0	0
Liked learning about mental health		1	6
Mental health activities were fun		1	1
Mental health activities were handled sensitively		1	2
Testimonies were good		1	6
Tips to improve mental health		1	3
Parents don't consider mental health important		1	1
Negative case		1	2
Pressure is intense to adapt		1	4
Discrimination		1	6
Feeling solo		1	5
Sadness affects school		1	2
Services embedded in schools		1	1
Teachers need assistance in meeting needs		1	1

APPENDIX N: FOCUSED CODES OF ADMINISTRATORS, DISCUSSED IN RELATION TO THE BIENVENIDO PROGRAM

Impact of Program:
<ul style="list-style-type: none"> Administrative support for the program is best evidenced by providing <u>time</u> to teachers or parent liaisons to be fully present during Bienvenido sessions.
<ul style="list-style-type: none"> Connection (in school, among friends, and in family) is an implicit and explicit goal of the Bienvenido program. It is also an outcome of the program.
<ul style="list-style-type: none"> The opportunity to speak in Spanish is comforting.
<ul style="list-style-type: none"> The topic of mental health is brought up to normalize it, give language to what they are feeling, and provide resources to manage it.
<ul style="list-style-type: none"> The Bienvenido program is a much-needed break from academics.
<ul style="list-style-type: none"> Connection begets confidence. (If participants feel connected and encouraged in the program, it leads to confidence and success in other areas [i.e. extra-curricular activities].)
<ul style="list-style-type: none"> The Bienvenido program serves as a reminder to the district and wider community that there are vulnerable students among us, and we have a responsibility to work together and take care of them.
<ul style="list-style-type: none"> Youth walk away with practical knowledge that will help them and others in social relationships.
<ul style="list-style-type: none"> The nature of the program was to introduce topics and let students explore if it was relevant to them.
<ul style="list-style-type: none"> Individualized support sessions were a very important complement to the Bienvenido classes because it allowed youth an opportunity to share traumatic experiences in a private, nonjudgmental, Spanish-speaking session(s).
State of Participants:
<ul style="list-style-type: none"> Participants lack parental support, but it may not always be due to lack of interest among the parents. Lack of parental support is tied to lack of transportation and/or lack of a specific contact person, such as a parent liaison at the school.
<ul style="list-style-type: none"> Mental health needs among newly-arrived immigrants are immense. The needs include addressing internalizing disorders like anxiety and externalizing disorders like anger management problems.
<ul style="list-style-type: none"> Youth are notably angrier than in the past—and anger can lead to displacement of anger in unhealthy activities. Anger is also rooted in trauma.
<ul style="list-style-type: none"> Anxiety stems from the confusion and disconnect of not knowing how to navigate a foreign system.

<ul style="list-style-type: none"> • Low literacy levels and/or learning disabilities affect students' success and self-efficacy—sometimes it's an insurmountable barrier.
<ul style="list-style-type: none"> • Lack of connection among youth and guardians is an enormous issue that underlies all other issues.
<ul style="list-style-type: none"> • Trauma intersects with the stress of new transitions—all of which undermines success at school (i.e. "I just can't concentrate.").
<ul style="list-style-type: none"> • Youth act "normal" like teenagers, but trauma lies beneath. Youth may not open up immediately, if at all.
<ul style="list-style-type: none"> • The consequences of any "teenager" mistake are harsher for immigrants due to immigration concerns.
<ul style="list-style-type: none"> • Youth walk a line between wanting to work and knowing they have to go to school. They face enormous pressure to earn money. School is perceived as taking time away from work, especially when they don't understand English at school and don't perceive themselves to be good at school.
<ul style="list-style-type: none"> • There is a bi-directional feedback loop between mental health and academics: Poor mental health and trauma negatively affect academics, and doing poorly in academics also affects their mental health and how they feel about themselves. Poor mental health and poor academics feed off each other.
<ul style="list-style-type: none"> • Youth have so much potential, but are currently so broken.
<p>Future of Program and Needed Supports:</p>
<ul style="list-style-type: none"> • There is a need for a deeper analysis of what resources exist at the schools, how to increase awareness of the resources among all parties (teachers, parents, students), and how to streamline access to the resources.
<ul style="list-style-type: none"> • Community-based mental health services are overwhelmed (and participants are waitlisted)—underscoring the importance of help within the context of the schools and during the school day.
<ul style="list-style-type: none"> • EL teachers are asked to help with mental health and integration needs, but they don't have the support to help (i.e. their full load of classes prevents them from being present in the classes). They need specific guidelines, structures, and protocols on a district level that would provide support, and the EL teachers should be able to provide input into those policies.
<ul style="list-style-type: none"> • Community centers/mentor-based services for Hispanic/Latinx students may be a path forward because it provides connection.
<ul style="list-style-type: none"> • Intensive mental health support is warranted for students, but it needs to happen within the context of the school or programs within the school day.
<ul style="list-style-type: none"> • Field trips to introduce youth and adults to community resources are helpful.

<ul style="list-style-type: none"> Needs are met on an “as needed” basis, but this likely contributes to anxiety among youth. A welcoming protocol with community/school resources integrated would be helpful.
<ul style="list-style-type: none"> Including additional “outside speakers” to provide testimony on a variety of topics is an engaging part of the program. A speaker to address suicide should be considered.
<ul style="list-style-type: none"> De-stigmatization of mental health is needed among the adult Hispanic/Latinx population because their lack of support for mental health can affect youth (i.e. not wanting their kids to go after school to do mental health-related activities because mental health “means you’re crazy”).
<ul style="list-style-type: none"> Continuous introductions/reminders to the program and its topics are needed at every level (i.e. administrators, parents, staff, teachers, and students). Doing so normalizes and integrates the program into the daily schedule (i.e. the students know they will be leaving class to go to the program and/or individualized support sessions; the teachers are aware and move the students along quickly, etc.).
<ul style="list-style-type: none"> A big gap is the school’s inability to reach out to current guardians of the youth. Restrictions on who the school can contact severely limit the ability to support the youth.
<ul style="list-style-type: none"> Learning and applying trauma-informed discipline is a need among school staff. Some schools are more lenient among students; others are not.
<ul style="list-style-type: none"> Time and scheduling adjustments could help the flow of the Bienvenido program.
<ul style="list-style-type: none"> It is important to look periodically at adding content to the Bienvenido program (i.e. gang-related content).
<ul style="list-style-type: none"> School staff, including counselors, may need education on why the Bienvenido program is important, so that they can better help support it.
<ul style="list-style-type: none"> The limited number of individualized support sessions is hugely problematic for the healthy functioning of the youth; without support, youth will endure unresolved trauma. They also risk “feeling stripped naked” by revealing information and then being dropped from accessing follow-up support.
<p>Suggestions for Improvement:</p>
<ul style="list-style-type: none"> Measure participants’ sense of connection among friends, family, and peers.
<ul style="list-style-type: none"> Consider diverse ways of reaching out to parents (i.e. What’s App, different meeting times) or other investments in additional staff.
<ul style="list-style-type: none"> A systematic study of the landscape of “resource availability and resource allocation” with the schools as an access point would be helpful.
<ul style="list-style-type: none"> Group counseling sessions that bilingual social workers do throughout the year is also an option.
<ul style="list-style-type: none"> Add another session in order to complete paperwork; negotiate more than one hour of class time.

APPENDIX O: FOCUSED CODES OF STUDENTS, DISCUSSED IN RELATION TO THE BIENVENIDO PROGRAM

Impact of Program:
<ul style="list-style-type: none"> • Speaking Spanish is a method to build connection and friendships.
<ul style="list-style-type: none"> • Youth desperately needed to talk to someone, and the social worker was the first person they felt safe enough with to share the seriousness of their struggles and seek advice.
<ul style="list-style-type: none"> • The act of gathering in person together and sharing experiences provides a sense of connection and solidarity among youth.
<ul style="list-style-type: none"> • Youth soaked up information about mental, behavioral, and social health. They loved learning about it--largely because they had never been encouraged to learn about these topics before.
<ul style="list-style-type: none"> • Youth learned strategies for their own lives, based on the testimonies that were given by other people.
State of Participants:
<ul style="list-style-type: none"> • Youth need help, but may not know how to ask for it, thus they pretend they are fine.
<ul style="list-style-type: none"> • The adaptation to the United States is a significant challenge for the youth (i.e. cultural shock is hard to overcome).
<ul style="list-style-type: none"> • Youth need and may look for help at school, but without Spanish-speaking resources, they may not access it.
<ul style="list-style-type: none"> • Youth face discrimination based on their accents or lack of English.
<ul style="list-style-type: none"> • Youth face overwhelming feelings of isolation and loneliness that make it extremely hard to concentrate at school-- "sticks can break the camel's back."
<ul style="list-style-type: none"> • Youth perceive others to not understand the immigrant experience, especially the fact that their home lives are unstable.
Suggestions for Improvement:
<ul style="list-style-type: none"> • Providing greater access to a counselor at school would help normalize seeking help for mental health.
<ul style="list-style-type: none"> • Youth want to discover and be recognized for their talents, even when they do not speak English well (i.e. do not reduce Hispanic/Latinx individuals to their ability to speak English or not).
<ul style="list-style-type: none"> • Youth would like strategies on how to best welcome other Hispanic/Latinx students.

- | |
|--|
| <ul style="list-style-type: none">• In order to combat discrimination, youth want to be instrumental in teaching others about their cultures. |
| <ul style="list-style-type: none">• There is not enough time for youth to explore the topics each week. More time is needed, either during the weekly sessions or by increasing the frequency of sessions. |
| <ul style="list-style-type: none">• Youth should be given adequate information about the Bienvenido program so they feel like active participants. |
| <ul style="list-style-type: none">• Consider rooms with more space, since there may be a lot of participants during a session. |

APPENDIX P: LINE-BY-LINE CODES FROM THE DE-IDENTIFIED NOTES DEVELOPED FROM THE TWO SOCIAL WORKERS INVOLVED IN THE BIENVENIDO PROGRAM; TABLES EXTRACTED FROM NVIVO 12 QUALITATIVE SOFTWARE

Name	Description	Sources	References
Brief intervention		2	5
Learning to accept social support from family members		1	1
Sessions helped students learn coping skills		1	1
Students' lives are still unsettled and unresolved		1	1
Therapy has benefited students		1	1
Comprehension of substance abuse		1	1
Despite comprehension, participation in substance use		1	1
Knowing it is better not to partake in substance use		1	1
Using drugs and alcohol to cope		1	1
Symptoms		0	0
Acculturation difficulty		1	1
Adjustment disorder		1	1
Depressive disorder		3	5
Disruption of family by separation or divorce		2	2
High expressed emotion level within family		1	1

Panic disorder		1	1
Post-traumatic stress disorder		2	2
Severe and moderate anxiety		1	3
Social anxiety disorder		1	1
Difficulty with acculturation		2	2
Adaptation to colder weather		1	1
More used to being outside and living more freely than being in enclosed areas		1	1
Discrimination against immigrant youth		0	0
Sexually abused youth seen as promiscuous		1	1
Educational attainment of immigrant youth		0	0
Education level varies depending on country of origin		1	1
Going to school in native country		1	1
Consistent education despite country of origin		1	1
Follow-up sessions are essential		1	3
Needed to establish trust before confiding about sexual assault		1	1
Ongoing counseling is needed		2	2
Periodic check-ins are needed to maintain mental health		1	1
Healing begins in safe place		1	1

Preference of using native language than interpreter		2	2
Sharing personal stories regarding struggles and fear		2	3
Using available resources to begin healing		1	1
Immigration circumstances		0	0
Being a U.S. citizen but being raised in another country		1	1
Coming to U.S. via caravan		1	1
Crossing border on foot, train, bus, etc.		1	1
Having a visa but being raised in another country		1	1
Undocumented or asylum-seeking status		1	1
Lack of social support from guardians		1	1
Extended family could not replace immediate family's support		1	1
Feeling rejected		1	1
There is minimal help and support for students		1	1
Living environments of immigrant youth		1	1
Eviction and relocation from living environment		1	1
Living with extended family		2	2
Living with immediate family		2	2

Living with someone outside of their family		2	2
Mental health risk factors of immigrant youth		0	0
Alcohol and substance abuse		2	2
History of attempts and self-harm behaviors		1	1
Hopelessness		1	1
Impulsivity		1	1
Recent loss		2	2
Suicidal ideation		2	2
Most immigrant youth have work experience		1	1
Half of immigrant youth have worked in home country		1	1
One quarter of immigrant youth report working part time or full time in U.S.		1	1
Need for mental health services		0	0
First time students were able to share their issues with another		1	1
Need for accessible mental health counseling		1	1
Mental health sessions/therapy can be in person or virtual		1	1
Onset of mental health issues began after immigration		1	1
Feelings of anxiety		3	3
Feelings of depression		3	3

Onset of depression after arrival to U.S.		1	1
Positive coping mechanisms of immigrant youth		0	0
Demonstrating leadership		1	1
Engaging in art		1	1
Engaging in music		1	1
Engaging in sports		1	1
Having a positive social life		1	1
Serving others		1	1
Utilization of faith to overcome mental health issues		1	1
Protective factors of mental health for immigrant youth		0	0
Cultural beliefs		1	1
Life satisfaction		1	1
Participants were socially engaged in extracurricular activities in native country		1	1
Positive coping skills		1	1
Positive social support		1	1
Religious beliefs		1	1
Reasons for immigrating to U.S.		0	0
Issues with family		1	1
Looking for better opportunities in life		1	1
Persecution		1	1

Violence		1	1
Reasons for not seeking out help		0	0
Cultural taboos around mental health services		1	1
Fears		1	1
Keeping issues to themselves		1	1
Lack of knowledge of services		1	1
There is a risk to sharing their story		1	1
Specific problems immigrant youth face		0	0
Abandonment		3	7
Break down of nuclear family upon entering new environment and culture		0	0
Feeling lost		1	1
Feeling pressured to be independent		1	2
Feeling unwanted		1	1
Gang activity		1	1
Grief		1	1
Homelessness		1	1
Language barriers		1	1
Loneliness		1	1
Missing a special relationship with a family member in their native country		1	1
Missing their homeland		1	1

Organized crime		1	1
Physical violence		1	1
Sexual abuse		2	3
Students have experienced abuse		1	1
Worried about family in native country		1	1
Students desire to progress in life		1	1
Students have persevered		1	1
Trauma experienced during immigration process		1	1
Trauma during immigration journey		1	1
Trauma from country of origin		2	3
Sexual abuse in native country		1	1
U.S. experiences necessitating mental health services		2	3
Trauma not recognized in U.S.		1	2
Why migration is hard for youth		1	1
Adapting to new culture		1	1
Difficulty adapting to new environment		1	1
Issues with living situation		1	1
Learning new language		1	1

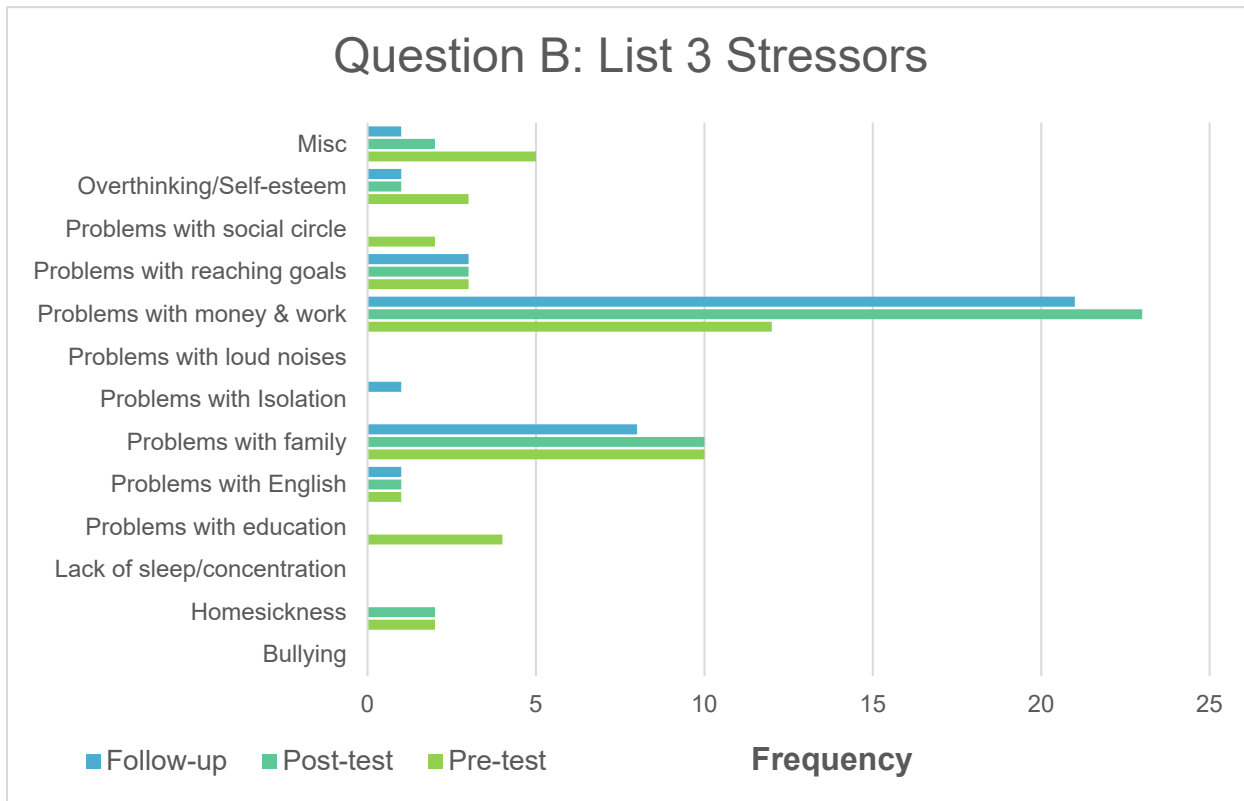
APPENDIX Q: DEMOGRAPHICS OF ADULT PARTICIPANTS INVOLVED IN THE BIENVENIDO PROGRAM AS REPORTED IN THE BIENVENIDO PRE-TEST SURVEY INSTRUMENT

Participant Demographics	<i>n</i> (Total <i>n</i>=17)	Percentage
Country of Origin		
Mexico	12	71%
United States	3	18%
El Salvador	1	6%
Guatemala	1	6%
Length of Stay in United States		
5+ yrs.	17	100%
Level of English Proficiency		
No English	2	12%
A Little	8	47%
Good	2	12%
Very Good	5	29%
Number of Years Working in Construction/Agriculture		
None	8	47%
1-4 yrs.	1	6%
5-9 yrs.	3	18%
10+ yrs.	4	24%
No response	1	6%

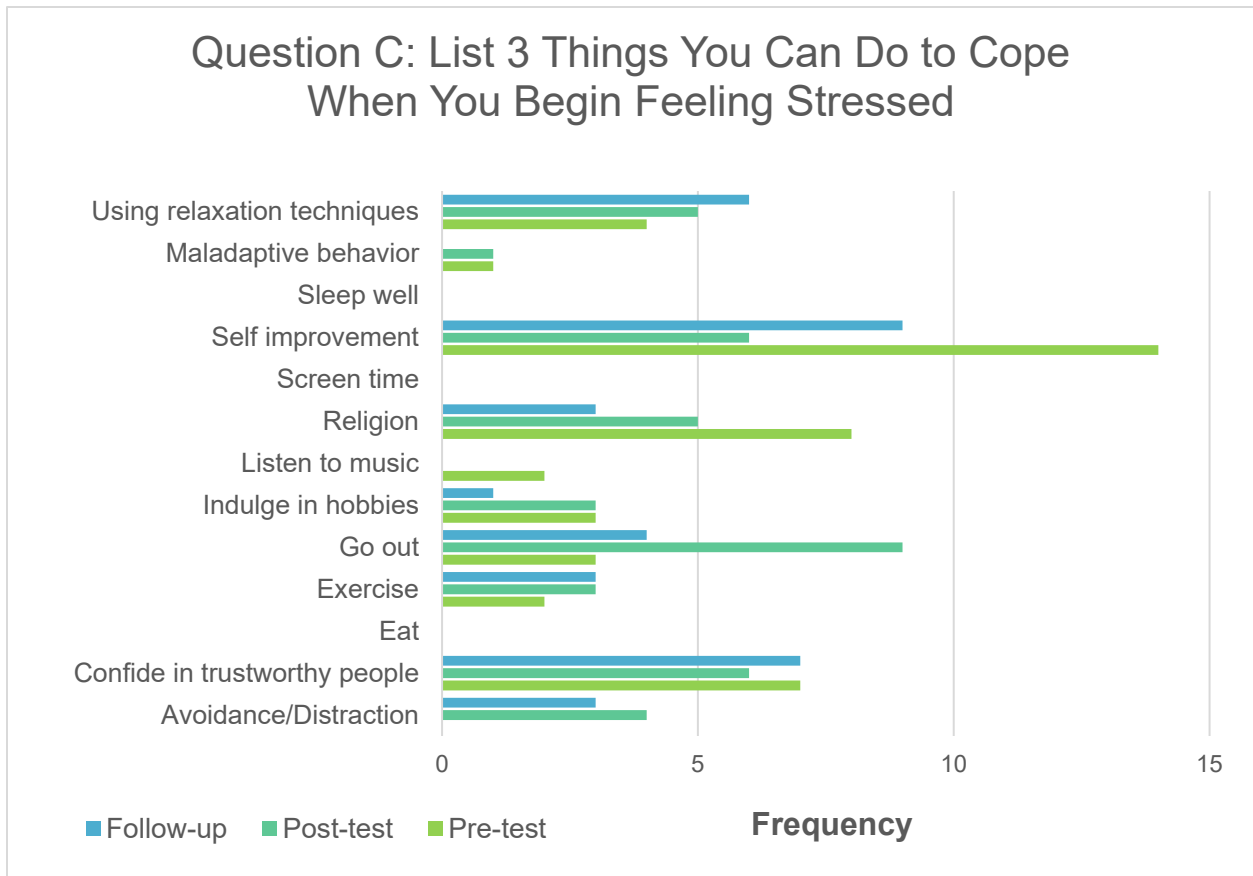
APPENDIX R: SAMPLE OF ADULT PARTICIPANTS THAT PARTICIPATED IN THE BIENVENIDO PROGRAM AND THAT RECEIVED INDIVIDUALIZED SUPPORT SESSIONS

St. Vincent de Paul Catholic Church (Elkhart, IN)	<i>n</i> (Total (<i>n</i>=17))	Percentage
Completed Survey Instruments		
Pre-test	17	100%
Post-test	14	82%
Follow-up	12	71%
Individualized support sessions		
Total # of sessions received	7	41%
1 session	5	71%
2 sessions	2	29%
3 sessions	0	0%
4 sessions	0	0%

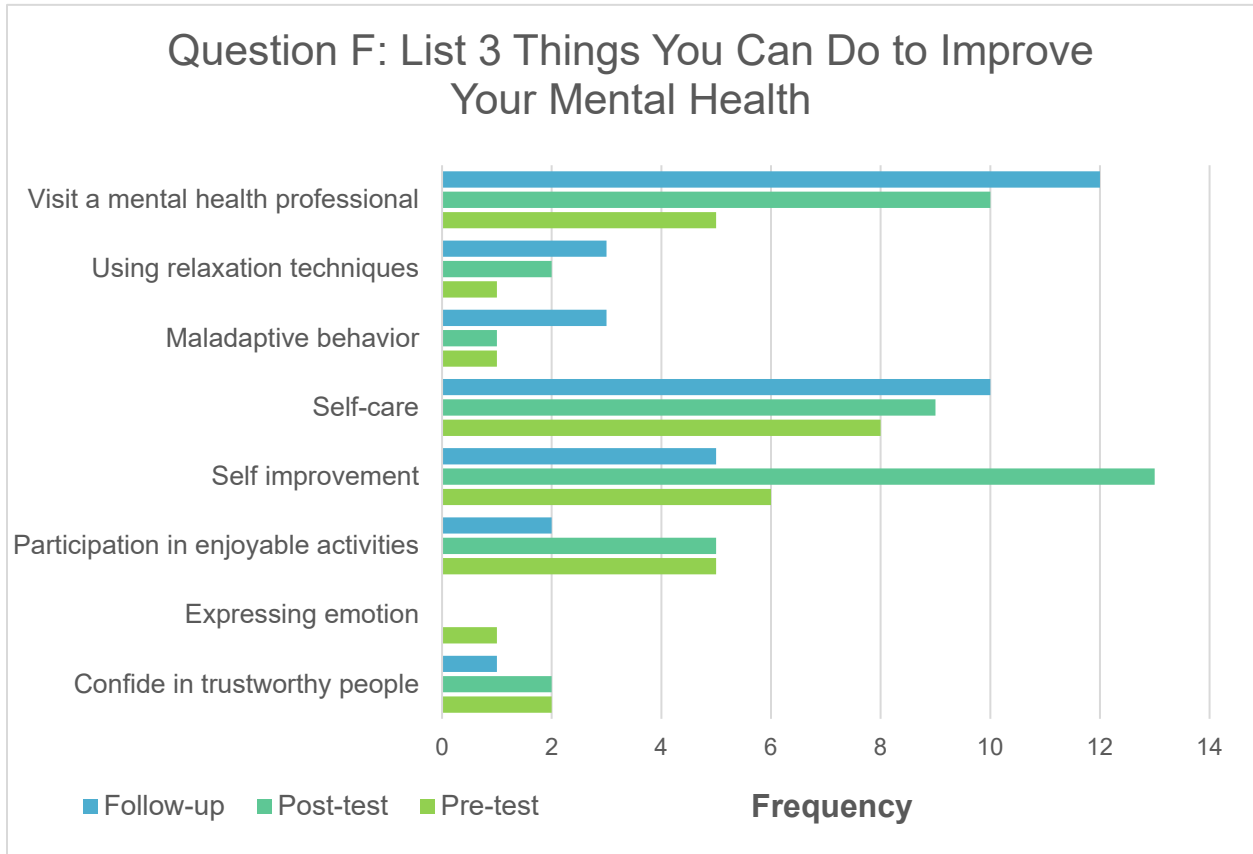
APPENDIX S: THE STRESSORS REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION B OF THE BIENVENIDO SURVEY INSTRUMENT



APPENDIX T: COPING MECHANISMS REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION C OF THE BIENVENIDO SURVEY INSTRUMENT



APPENDIX U: TECHNIQUES TO IMPROVE MENTAL HEALTH REPORTED BY ADULT PARTICIPANTS FROM ST. VINCENT DE PAUL CATHOLIC CHURCH (ELKHART, IN) AS NOTED IN QUESTION F OF THE BIENVENIDO SURVEY INSTRUMENT





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